INPATIENTS' AND THEIR FAMILIES' PERSPECTIVE OF MENTAL HEALTH TREATMENT

A THESIS

SUBMITTED TO THE FACULTY OF ATLANTA UNIVERSITY

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR

THE DEGREE OF MASTER OF SOCIAL WORK

BY

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SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA

MAY, 1967

DEDICATED

TO

MY HUSBAND, RICHARD N. WARE
AND
OUR CHILDREN
RICKY, GREGORY, ADORIA, CHRISTOPHER, MARY, AND PATRICK
WITHOUT WHOSE PATIENCE, UNDERSTANDING
AND SUPPORT THIS THESIS WOULD NOT
HAVE BEEN POSSIBLE

ACKNOWLEDGMENTS

To the Georgia Mental Health Institute for their cooperation in making this study possible: with special thanks to

Mr. Paul Hebert, Director, Social Work Service and Mr. Winter Giddings, Assistant Director, for submitting the research proposal to the Institute Research Committee for approval and for making it possible for the researchers to use Institute equipment and supplies.

Miss Betty Timberlake, Miss Barbara Brown and Mrs. Naomi Ward, the Chief Social Workers, for arranging meetings with the Unit Directors and for submitting written descriptions of their respective units' operational procedures.

Dr. Esteban V. Castillo, Dr. Ralph Roughton and Dr. Julian Gomez, the Unit Directors, for soliciting patient and staff cooperation on their respective units.

Miss Sandra Colquitt for her assistance in typing letters, questionnaires, memos and other items necessary to conduct this research study.

Vocational Rehabilitation for their kindness in permitting the researchers to use their office equipment during office hours.

The inpatients and their families for sharing with us their feelings, attitudes and opinions concerning the treatment services.

To Mr. Lloyd Yarborough, Research Instructor, Atlanta University School of Social Work, for his assistance and astute criticism concerning the writing of this thesis.

This Thesis In Its Entirety

Was Done In Conjunction With

Eleanor Bartlett

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CHAPTER I

INTRODUCTION

STATEMENT OF PROBLEM

This is a descriptive study, the purpose of which is to assess and compare the positive and negative features of individual therapy, milieu therapy, and social work services extended to the inpatients and their families receiving treatment in the three adult units at the Georgia Mental Health Institute, Atlanta, Georgia, 1966. The evaluation will be secured through the analyses given the researchers by the patients and families themselves.

It must be understood that this study is limited only to the evaluation of the treatment services in terms of the way they are experienced by the inpatients and their families. In no way is this study dealing with the effectiveness of the treatment in relation to speed of patient recovery or in relation to achieving desired goals of patient improvement. These would require techniques for measuring improvement. This study is an attempt to allow the treated to teach those treating what it feels like to be on the other side of the fence and what from that side of the fence is most meaningful.

Just as it is beginning to be understood that the poor are the experts on their feelings, problems and desires so are the patients. With the knowledge gained by the professionals from these people, the professionals can better use their skills. There is a mutuality in teaching and sharing. The trained have the skills and general know-

ledge that the untrained lack but both of these are useless unless they penetrate from the general to particular which involves learning from the patients what their feelings are.

DESCRIPTION OF THE RESEARCH SETTING

The Georgia Mental Health Institute is a state institution which holds three primary functions -- research, teaching, and service. It has been admitting inpatients since November 30, 1965. The three existing adult units have three separate staffs which operate as teams. The teams are multidisciplinary in nature and consist of psychiatrists, psychologists, nurses, chaplains, social workers, a dietician, an occupational therapist, a vocational rehabilitation counselor, a music therapist, a social work aide, and psychiatric assistants. The three units are basically similar in the number of persons on their staff and in their physical and recreational facilities. Each of the three units has a heterogeneous population in regard to the clinical diagnosis, the sex, the age and the income level of its patients. Usually the patients who may be at present suicidal, homocidal or elopement risks are placed on Unit A as this is the only unit which is physically equipped to handle these problems. All patients enter the Institute of their own volition.

The patients, unless physically ill, dress every day. They spend the day going to different activities, their therapy session, and interacting with the other patients and staff in the lounges on their unit. They can listen to music, watch television, read, write, talk or play games.

There is enough flexibility in this new institution for each unit's staff to improvise and to experiment with the milieu. Due to the differences in the theoretical perspectives of the respective unit staffs, differences in operational procedures on the unit have occurred. For this reason, this study has as one of its major concerns the effect of these different practices in the three units. This will be based on the analyses offered by those being served rather than by those serving.

REVIEW OF THE LITERATURE

Theories regarding the emotionally disturbed, as well as the treatment of these individuals, has grown increasingly more sophisticated, more flexible and more humane since World War II. The fear of the emotionally ill individual is being slowly replaced by the respect for his human dignity. No longer do the mental health professions regard psychiatric patients as almost subhuman species who must be rigidly controlled and confined. The trend is towards an increasing respect for the patient's ability to participate in his own treatment and to participate in handling the problems of the patient community. Harry A. Wilmer describes some of these inhumane conditions in a state mental hospital where he was working prior to World War II in the following manner:

> I walked away from the ward overwhelmed by the utter isolation of these patients, vacant-faced, forgotten, sitting like automatons through their empty endless days. No one seemed to belong to anyone or even be anyone. The experience has remained fresh in my

> memory and has colored my thinking on patient management in all the intervening years.[1]

There has been movement from the type of theory which produced the conditions described by Wilmer to the new theory as exemplified by T. F. Main. Main first specifies the problem of patient desocialization which results from the implementation of the traditional hospital theory which is based on charity and discipline and which judges a patient good or bad according to how passive he is or how easy he is to handle.[2] Main describes his theory thusly:

> The daily life of (the hospital) community must be related to real tasks truly relevant to the needs and aspirations of...the rest of the society; full opportunity must be available for identifying and analyzing barriers which stand in the way of participation in a full community life.[3]

Main sees the patient as a participant in his treatment and not solely as a recipient of treatment.

Theory in the field of mental health is relevant only if it becomes actively implemented in the field of practice. It is only through implementation that theory can be tested. Studies of "personality functioning as a part of institutional functioning"[4] had their beginning in 1929 to 1931 with the work of Harry Stack Sullivan at Enoch Pratt

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[1]Harry A. Wilmer, Social Psychiatry in Action (Springfield, Illinois: Charles C. Thomas, Publisher, 1958), 4.

[2]T. F. Main, "The Hospital as a Therapeutic Institution", Bull Menninger Clinic, X (1946), 66-70.

[3]Ibid., 69.

[4]Alfred H. Stanton and Morris S. Schwartz, The Mental Hospital (New York: Basic Books, Inc., 1954), 13.

Hospital in Townsend, Maryland.[1] In studying a schizophrenic ward, Sullivan found it beneficial to the patient to segregate the ward according to the clinical diagnoses of the patients and to impose a rigid time schedule. The Georgia Mental Health Institute does not segregate its units according to the clinical diagnoses of the patients. However, the structured time schedule is often used with schizophrenic patients.

The historical trend both in outlook on the emotionally disturbed and the use of the hospital for treatment need to be noted. Prior to World War II Mental Hospitals were more like custodial prisons with the exception of persons like Harry Stack Sullivan who provided rare pioneering spirit. World War II cracked open the mental health field. Due to the number of army personnel with emotional problems and the shortage of staff experimental approaches began to occur within the hospital. With the advent of the '50's began the movement to break down the seemingly impermeable barriers between the hospital and the community. Psychiatric sections developed in general hospitals. Family treatment became emphasized. The open door policy began to be used and many custodial patients were returned to families. The milieu within the hospital became extremely important and the aftercare programs of moving patients back into the community became significant. The 1960's brought the next step in the movement-community mental health.[2]

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[1] Harry Stack Sullivan, "Socio-psychiatric Research: Its Implications for the Schizophrenia Problem and for Mental Hygiene," American Journal of Psychiatry, X (1931), 991-997.

[2] Melvin Shabshin, "The Boundaries of Community Mental Health," The Social Service Review, XL (September, 1966), 247-248.

This movement shows the growing significance of two areas of this study - the milieu and social work service. In order for hospitalized patients to return to the community the milieu within the hospital needs to be more realistically similar to the outside world so that the patient can experiment and learn new ways of adjusting. Secondly, the milieu to which the patient returns usually involves the family. For this reason, the unhealthy aspects of this milieu need to be dealt with. As more treatment is centered around the family fewer patients may have the need to be hospitalized. This will be possible only when there are community hospitals.

The work of Maxwell Jones at Mill Hill Hospital in Europe and Southern Hospital in Dartford, Kent, England during World War II revealed the beneficial effects of a therapeutic community. In both the military hospital for psychosomatic and conversion reaction difficulties and the special unit for returning prisoners of war, Maxwell Jones introduced the practice of having all members of the staff operate as a team. Not only did he break down the traditional hierarchy in staff, but he also began patient group meetings which were both educational and therapeutic. He also used psychodrama, initiated job training, and dealt with the resocialization of patients. The patients aided the staff team in handling problems which arose on the ward. Jones' theory is that "the whole of a patient's time spent in the hospital is thought of as

treatment."[1] Allen,[2] Bowen,[3] Branden,[4] and Schatzman[5] have also done studies which deal with and support the use of staff as a team.

Further research on the significance of an appropriate institutional milieu was done by Anna Freud and Dorothy Burlingham at the Hampstead Nursery. Bruno Bettleheim and Emmy Sylvester also did research in the relationship between the institutional climate and procedures and the reaction of children in their physical, emotional, and intellectual development.[6]

Devereux, in his study of psychotics in a large mental hospital recommended taking out the vertical status hierarchy and formalizing some of the informal social activities among patients.[7] Szurek has also

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[1] Maxwell Jones, The Therapeutic Community (New York: Basic Books, Inc., 1953), 53.

[2] Elizabeth R. Allen, "The Operation of the Clinical Team in the Intensive Treatment Unit at Northville State Hospital" (unpublished Master's Thesis, School of Social Work, Atlanta University, 1958).

[3] William T. Bowen, Don C. Marler, and Leroy Androes, "Psychiatric Team: Myth and Mystique," American Journal of Psychiatry, CXXII (April, 1961).

[4] Mildred G. Branden and Edgar B. Jackson, The Team Concept: A Project on Resocialization of Patients in a Mental Hospital (New York: Family Service Association of America, 1961).

[5] Leonard Schatzman and Rue Bucher, "Negotiating a Division of Labor Among Professionals in a State Mental Hospital," Journal of Psychiatry, VII (1964).

[6] Bruno Bettleheim and Emmy Sylvester, "A Therapeutic Community," American Journal of Orthopsychiatry, XVIII (1948).

[7] G. Devereux, "The Social Structure of a Schizophrenia Ward and Its Therapeutic Fitness," Journal of Clinical Psychopathology, VI (1944), 231-267.

studied the relationship between the problems of the staff and the condition of patients on the unit.[1]

In developing a therapeutic milieu, Schwartz considers three dimensions to be associated with extending the therapeutic functions beyond the psychiatrist to others in the hospital. These dimensions are: (1) "who is therapeutically significant for patients? (2) what activities and functions of patients and personnel are to be considered therapeutically significant? and (3) how are therapeutic functions broadened?"[2]

"The goal of the therapeutic milieu is to achieve enduring changes in the patient's patterns of interpersonal relations (in his emotional life and in his personality) so that it is unnecessary for him to live in an emotionally ill way."[3] In order to accomplish this the milieu must provide corrective experiences and support the healthy part of the individual. The psychological climate in order to be therapeutic must fulfill the following needs:

> (1) provide the patient with experiences that will minimize his distortions of reality, (2) facilitate his realistic and meaningful communicative exchange, (3) facilitate his participation with others so that he derives greater satisfaction and security therefrom, (4) reduce his anxiety and increase his comfort,

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[1] S. A. Szurek,"Dynamics of Staff Interaction in Hospital Psychiatric Treatment of Children," American Journal of Orthopsychiatry, XIX (1949), 492-500.

[2] Morris S. Schwartz, Charlotte Green Schwartz, et al., Social Approach to Mental Health Care (New York: Columbia University Press, 1964), 172-174.

[3] Morris S. Schwartz, The Patient and the Mental Hospital (Glencoe, Illinois: Free Press, 1957), 46.

> (5) increase his self-esteem, (6) provide him with insight into the causes and manifestations of his mental illness, (7) mobilize his initiative and motivate him to realize more fully his potentialities for creativity and productiveness.[1]

Wesson defines the therapeutic community as "an effort to mobilize all aspects of the social milieu including the physical and social structure of the treatment center."[2] The community itself should serve to complement the individual psychotherapy, the pharmacological techniques and the organic therapies.

Many contributions to the mental health field have been made by the Joint Commission on Mental Illness which was established in 1955 "to encourage research and a re-evaluation of all aspects of our resources, methods, and practices for diagnosing, treating and rehabilitating the mentally ill."[3] President Kennedy exerted great influence in that he was the first Chief Executive to make an address to Congress concerning treatment of the mentally ill. It was he who said, "The time has come for a bold new approach."[4] Plans developed for new hospitals, better staffs and community hospitals. The Georgia Mental Health Institute is an outgrowth of this "bold new approach".

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[1] Ibid, 131.

[2] Albert F. Wesson, The Psychiatric Hospital as a Social System (Springfield, Illinois: Charles C. Thomas Publisher, 1964), 147.

[3] A. L. Seale, Ronald S. Pryer and W. S. Easterling, "The State Hospital in the 'Bold New Approach' to care for the Mentally Ill", Mental Hygiene, L (October, 1966), 601.

[4] Ibid, 602.

The significance of the type of milieu the hospital itself provides is pointed out in this statement by Maurice Vanderpol and Alfred H. Stanton: "The possibility that (psychological) phenomena vary to some extent as a function of the psychiatric hospital environment has become more and more apparent as the hospital structure itself has become recognized as a variable of major clinical importance in the course of mental illness."[1]

As has been said since the 1940's and particularly since the 1950's, counseling the family of an institutionalized patient has become increasingly significant. One basic assumption underlying this move to include families in the treatment of a patient is that "some kind of interrelatedness exists among family members...the family consists of interdependent individuals who exist within a common boundary."[2] A second assumption is that "the family is the most important shaper and influencer of human destiny, the matrix in which human development takes place."[3]

The sickness of one family member may be perpetuated or reinforced by other family members. This reveals a family dysfunction which

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[1] Maurice Vanderpol and Alfred H. Stanton, "Observations on the Effect of Environment on Schizophrenic Behavior in the Psychiatric Hospital," Psychiatry: Journal of the Study of Interpersonal Processes, XXIX (November, 1966), 412.

[2] William G. Hill, "The Family As A Treatment Unit: Differential Techniques and Procedures," Social Work, XI (April, 1966), 63.

[3] Frances H. Scherz, "Family Treatment Concepts", Social Casework, XLVII (April, 1966), 234.

needs to be handled in order for the patient to gain control over his illness. "The approach utilized is based on the belief that the family is an organized entity having a reality in itself with the behavior of the family members possessing patterned characteristics."[1]

Family equilibrium is an important factor in relation to helping a patient and his family. The family equilibrium is defined as "The family's design to provide avenues of stability and change in the interest of performing life tasks and fulfilling growth needs as economically as possible."[2] This involves the establishing of roles and patterns of behavior on the part of each family member. Marital equilibrium or complementarity is a significant factor. Every family member effects and is effected by the equilibrium, which "may be adaptive in some aspects and maladaptive in others or may be predominantly one or the other."[3]

Frances Scherz points out several types of family constellations which may be seen in treating patients. First is the socially and psychologically unstable equilibrium in which there is a confusion of roles with the constellation itself more sibling in nature than parent-child. There is usually a prevalence of primitive behavior and these

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[1] Scott Briar, "The Family As An Organization: An Approach to Family Diagnosis and Treatment," Social Service Review, XXVIII (September, 1964), 250.

[2] Scherz, op. cit., 235.

[3] Ibid.

families often become the multiproblem type. A second type of family constellation is the one which has a flexible adaptive equilibrium but is temporarily dysfunctional due to some crisis. The third type is the neurotic family constellation where the patterns are both adaptive and maladaptive. Ambivalence seems to be the strongest characteristic. There is ambivalence regarding the explicit roles, in the implicit internal conflict and in family relations. Fourthly, within the psychotic equilibrium there is pervasive double-bind communication.[1]

Often the family equilibrium remains outwardly stable until a family maturational task such as a child's entering adolescence evolves. This task often breaks down or threatens an unhealthy equilibrium in which the parents have depended on the child to fill needs not met by each other. In this case the family is unable to support the growth and independence of the child. The result is often an emotionally extreme approach to adolescent adjustment on the part of the child.[2]

Thus the need to treat the family to which the patient will return or from which he is breaking away becomes obvious and is the responsibility of the social worker. The social worker also has the primary responsibility of educating families about mental illness, helping them to understand the patients difficulty and supporting them through the

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[1] Ibid, 238-240.

[2] Rae B. Weiner, "Adolescent Problems: Symptoms of Family Dysfunction", Social Casework, XLVII (June, 1966), 373-374.

patients and perhaps their own steps in becoming better functioning individuals. Some of the families do not have major dysfunction and with these the emphasis is on helping them to understand the patient, their role in relation to the patient and their acceptance of the problem. Most families need to be supported as they work through their guilt feeling and often ashamed feelings of having a mentally ill family member. At the Georgia Mental Health Institute family members are seen by the social worker alone and in some cases by the doctor and social worker in joint interviews with the patient. Hence social work service is a significant part of any mental health setting and social workers need to know all they can about the feelings of family members who are receiving their services.

How does one measure the therapeutic value of the experiences of the patients in a mental hospital? What particular aspects of the treatment process does the patient perceive as being more significant than others? What to the patient is unhelpful? What does the family and a patient perceive as most significant and/or lacking in its relationship with the helping person? These are the questions with which this study is concerned. To answer these questions the researchers turn to their best resource -- the inpatients and their families.

BASIC ASSUMPTION

Underlying this thesis is the basic assumption that an individual, although emotionally disturbed, has some ability to evaluate the treatment he is receiving. This assumption applies to the psychotic patient as well as neurotic patient or the patient with a character disorder.

This assumption is substantiated in the writings of others. For example, Carl Rogers relates "short term and long term satisfaction can be recognized, not by what others say, but by examining one's own experience . . . (because) he has within himself the capacity for weighing the experimental evidence and deciding upon those things which make for the long run enhancement of self."[1]

Howard Roland in his study done in the late 30's at a state mental hospital, learned that patients "organize themselves in an informal way for learning about events in the hospital."[2] Patients informally organized ways and means to keep up appearances before physicians and for other purposes related to their life in the hospital.[3] This illustrates Roger's view that a patient is aware and can assess what is going on around him.

Also Caudill, Redlich, Gillmore and Brody studied the ways in which patients indoctrinated new patients. They found that patients had a realistic awareness of why they were hospitalized, how they should treat each other and what they would need to do in order to get better.[4]

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1 Carl R. Rogers, M.D., Client Centered Therapy (Boston: Houghton Mifflin Co., 1951), 150.

2 Howard Roland, "Interaction Processes in State Mental Hospitals," Psychiatry, I (1938), 329.

3 Ibid.

4 William Caudill, Frederick C. Redlich, Helen R. Gillmore and E. B. Brady, "Social Structure and Interaction Processes on a Psychiatric Ward," American Journal of Orthopsychiatry, XXII (1952), 413-434.

Hyde and Solomon tried self-government with psychotic patients and contrary to their expectations, got good results.[1] Zenberh found in his study at a large mental hospital that patients "exercised better judgment in deciding which patients should go off the grounds than the psychiatrist had been able to do before a patient organization was set up."[2]

These studies illustrate that the patient, whether psychotic or neurotic, has an awareness of his interaction with his surroundings, a certain degree of insight regarding this interaction, and an ability to participate in dealing with problems which arise within the interaction.

A political science paper prepared by one of the patients on Unit A at the Georgia Mental Health Institute gives a good example of a patient's awareness of his interaction with staff members and/or other patients and of his insight into his behavior. The following is a quote from this paper:

> The actual role that (I) play in this system is the role of a patient enrolled in full-time psychiatric treatment. However, at times (I) attempt to change (my) role from patient to a staff member. This attempt to switch roles his (sic) due to the hatred (I have) for (myself).[3]

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1 R. W. Hyde and H. C. Solomon, "Patient Government: A New Form of Group Therapy," Digest of Neurology and Psychiatry, XVIII (1950), 207-218.

2 Stanton and Schwartz, op. cit., 22.

3 Patient A, "An Analysis of the Elementary Political System that Existed Between (Patient A) and Certain Members of the Unit A Staff of The Georgia Mental Health Institute," unpublished paper (1966), 2.

DEFINITION OF IMPORTANT TERMS AND CONCEPTS

Individual therapy refers to the treatment in which a patient is involved with his primary therapist who may be either a psychiatrist, psychologist, chaplain or social worker. Every inpatient at the Institute receives individual therapy at least twice a week.

Milieu refers to the psychological climate of the environment in which the patient interacts with both staff and other patients during his stay in the hospital. This not only involves the climate in which the patient interacts in the formal and informal activities on the unit but also the nature of their interactions with staff and patients in occupational therapy, music therapy, recreational therapy and vocational rehabilitation.

Beginning period of therapy refers to the first four weeks of treatment after admission as an inpatient.

Intensive period of therapy does not refer to the type of therapy being given (example, psychoanalytic or supportive) but rather to the time span in which a patient is receiving treatment following the first four weeks after admission and preceeding the first three weeks prior to discharge.

Termination period of therapy refers to the last three weeks of inpatient treatment prior to discharge.

A unit at the Institute consists of twenty-two to twenty-five patients. Each unit is a living area in itself which has bedrooms, baths, kitchen and dining facilities, lounges and certain recreational facilities,

such as television, record player, and indoor games. In addition, there is a nursing station and offices for the staff.

Adult for the purposes of this study is defined as anyone fifteen years of age or older.

Social Work Service for the purpose of this study, is primarily concerned with the counseling of families of inpatients at the Georgia Mental Health Institute. (It should be understood that social workers may also be the primary therapist for inpatients and outpatients; however, the specific concern of this study is for the treatment received by the families of inpatients.)

METHODOLOGY

The population of this study includes all the adult inpatients and their families who have received services at the Georgia Mental Health Institute. The sample population consists of all of the inpatients and families who were receiving treatment or services in one of the adult units on November 21, 1966.

The instruments to be used in this study are two open-ended questionnaires, one to be answered by the inpatients and one to be answered by the families. The questionnaire issued to the inpatients dealt with individual therapy, and milieu therapy. The questionnaire issued to the families dealt with social work service. A copy of these questionnaires is included in the appendix. The questionnaire was mailed to the families, along with a letter of explanation. They were given ten (10) days in which to respond.

The two researchers held a group meeting with the inpatients on each adult unit in which they explained the nature of the study and the use of confidentiality. The questionnaires were administered at this time. The researchers remained with the patients until the forms were completed in order that they could answer any questions and assist in structuring those patients who had difficulty in structuring themselves. These meetings with each unit were held on the evening of November 21, 1966. In this way communication between patients who had answered the questionnaire and those who had not would be avoided.

The patients as well as the families were asked to sign their questionnaire in order that the researchers would be able to obtain information from the patients' charts regarding (1) the unit in which they receive services, (2) the clinical diagnosis of the inpatients, (3) the sex of the patient and (4) the date of admission and/or the anticipated date of discharge. Once this information was obtained and the patients coded according to number, the names were not used in any other way. Prior to the removal of the name, the questionnaires were seen only by the researchers.

The researchers requested the chief social workers to prepare a statement regarding the operational procedures of their particular unit. This information makes the comparisons of the patients' responses concerning milieu therapy more meaningful and relevant to future practices in mental health facilities.

Since the questionnaire was open-ended, the answers had to be categorized according to the nature of the responses. The categories

were devised by employing the actual words used by the patients and their families; for example: "better understanding of self and others." Each category in each variable was given a code number from 0 - 10. Once this was completed, an IBM card was processed for each patient and family member with the coded information applicable to that patient or family member. The IBM cards were used to sort and tabulate the data. The responses to the three questions asked of the patients regarding individual therapy and milieu therapy and of the families regarding social work service were sorted and tabulated according to the four variables studied: The unit in which treatment was being received, the sex of the patients, diagnosis of the patients, and the period of treatment. Graphs were made showing the percentage of responses as well as the frequency of responses to the questions in each of the four variables. The data was then studied to assess and evaluate the positive and negative aspects of individual therapy, milieu therapy and social work service as seen by those receiving these services. The four variables were used only to determine if these in any way effected the responses from the patients and their families and their perception of the helpfulness of the services received. Any differences which these variables made is dealt with. However, this study's major emphasis is on those concerns shared by patients and families regardless of the variables.

LIMITATIONS OF THE STUDY

Major limitations of this study include the use of an open-ended

questionnaire, the use of the question "What has not been helpful?" regarding individual therapy, milieu therapy and social work service, and the differences of sample sizes of patients with different diagnoses, of different sexes and in different periods of treatments. This also caused the corresponding family samples in these variables to be unequal.

Since the researchers could find no similar studies in which those being treated were used as the source to evaluate the treatment services, they had no resources from which to devise a multiple choice questionnaire. Thus rather than trying to surmise or to prejudge what the patients would find meaningful, they decided to use an open-ended questionnaire, in which the patients would be free to respond spontaneously to what was meaningful to them. However this meant that the responses were varied and the frequencies attached to the responses were scattered and low. Thus little statistical significance could be gained from the data. Also the mood of the patient at the time of the questionnaire may have influenced the patient's or family's response. It may have been wiser to do a retest on a different day in order to try to assess how much mood played a part in the study.

The question "What has not been helpful?" proved to be threatening. A high percentage of patients and families gave no answer to this question. Even though confidentiality was explained, many patients still seemed to fear repercussions if they answered honestly. A question which does not require such an absolutely negative value judgment would probably have gained more response. For instance the question "What would be more

helpful?" had a good response. This question allowed the respondent to reveal a weak area through a positive suggestion. The question could have been left out or the term "less helpful" could have been used instead of "not helpful".

The sample sizes in relation to the three variable, sex, diagnosis and period were so different that the findings could not be conclusive. Whether or not these variables influenced patient responses can only be implied and not proven. If the samples had been equal, the findings might have been different. In diagnosis the samples varied from thirty-four to one. In sex from forty-six to sixtten and period from ten to thirty-six.

One last limitation is that all the possible influencing variables were not studied. For example, the mood of the patient on the day he answered the questionnaire was not considered. Neither were the patients expectations or goals of treatment. Thirdly, socioeconomic class and the rural-urban variables were not considered. All of these may have effected the patients' and families' responses.

INTRODUCTION

TO

CHAPTERS II, III, AND IV

This study seeks to acquire an understanding of the treatment services--individual therapy, milieu therapy, and social work service--as they are evaluated by those receiving the services. In order to do this certain variables had to be isolated which might determine or influence responses. For this reason the variables of unit, diagnosis, sex and period of treatment were selected. The patients answered the questions relating to individual therapy and milieu therapy and the families answered the questions relating to social work services. These chapters present and deal with the data as it relates to the three treatment areas and as it is influenced by the variables. Any implied differences which the variables seem to make are dealt with extensively in these chapters. Chapter V shall concentrate on the areas of concern shared by the patients and the families regardless of the four variables. These areas of similarity are pointed out in this chapter. In those instances where percentages are cited in the figures of the next three chapters, they total 99.9 per cent.

CHAPTER II

ANALYSIS OF THE DATA: INDIVIDUAL THERAPY

QUESTIONS ASKED

Regarding your one-to-one therapy:

1. What has been most helpful to you?
2. What would be more helpful to you?
3. What has not been helpful to you?

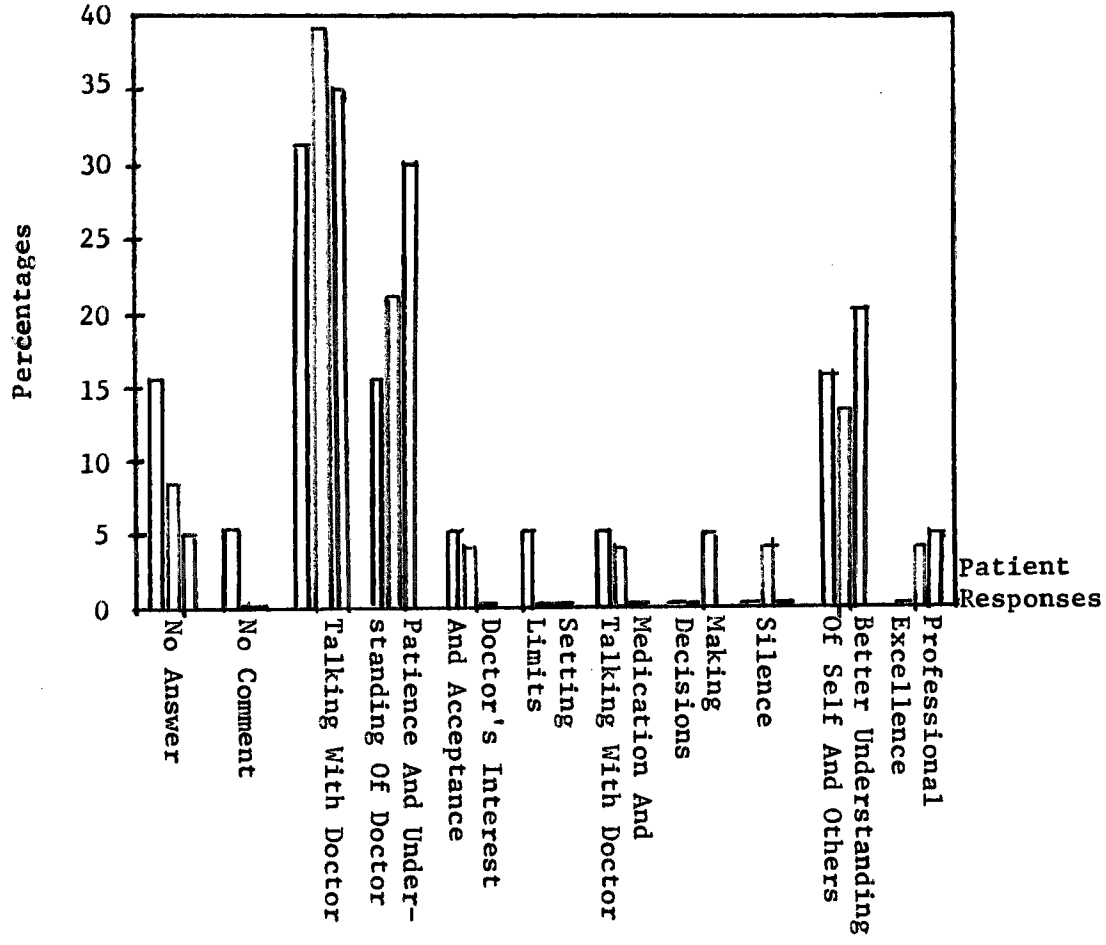
UNIT

The Unit on which a patient is being treated does not appear to effect his response in regard to what has been most helpful in individual therapy. This is illustrated by the fact that the responses from all three units tend to cluster around the same areas.

What Has Been Most Helpful To You?--Figure 1 reveals that the four areas of greatest patient concern in each unit are, in descending order: "talking with the doctor", "patience and understanding of the doctor", "better understanding of self and others" and "no answer". The only exception to this order is that within Unit A, the last three categories mentioned were of equal importance. Although the cluster of responses from all three units tended to be in the same general areas, there were individual responses to this question which were unique to a particular unit. For example, the responses of "no comment" and "setting limits" were answers given

Figure 1 - Individual Therapy

What Has Been Most Helpful?



Key - **Units**

Unit A ☐ N = 19

Cottage I ☐ N = 23

Cottage II ☐ N = 20

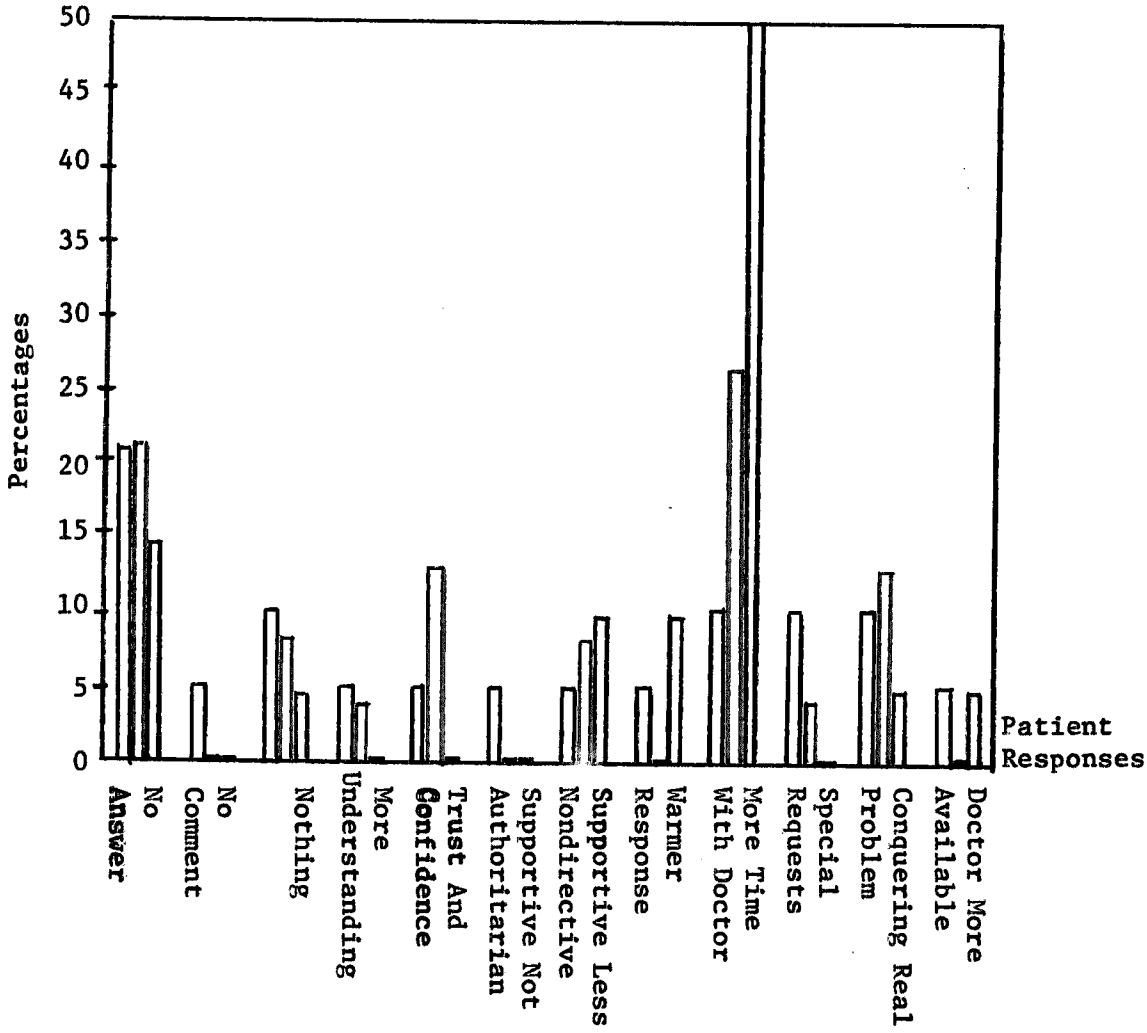
only by Unit A patients and the responses of "silence" and "making decisions" were given by one patient in Cottage I and Cottage II respectively.

What Would Be More Helpful To You?--In response to this question, the unit did make some difference as seen in Figure 2. This difference was seen as far as the peak response was concerned. Unit A had the largest percentage of patients (21 per cent) who did not respond to this question as compared with Cottages I and II whose peak response was in the area of "more time with doctor." Although the peak response for Cottages I and II was in the same area, there was a wide difference between the percentage of patients giving the response, 27 per cent in Cottage I and 50 per cent in Cottage II. The response "more time with doctor" on Unit A tied with "conquering real problem", "special requests" and "nothing". This may be due to the fact that the patients on Unit A are the more "disturbed patients" and require more individual attention than the less disturbed patients because of crises that arise which need immediate handling. In addition to this factor, the physical structure of Unit A gives the patients more access to the therapists. During the period of this study, two psychiatric residents, a psychology intern, and a chaplaincy intern had offices within the ward proper. The offices of other therapists on this unit were on the same floor as the ward. In the two cottages, the patients are housed on one floor and the offices of the therapists are located on another floor.

The second highest peak response in Cottage I and Cottage II

Figure 2 - Individual Therapy

What Would Be More Helpful?



Key - Units

Unit A ☐ N = 19

Cottage I ☐ N = 23

Cottage II ☐ N = 20

Special Requests:

Patient-Family Interview With Social Worker

Becoming Night Patient

More Medication

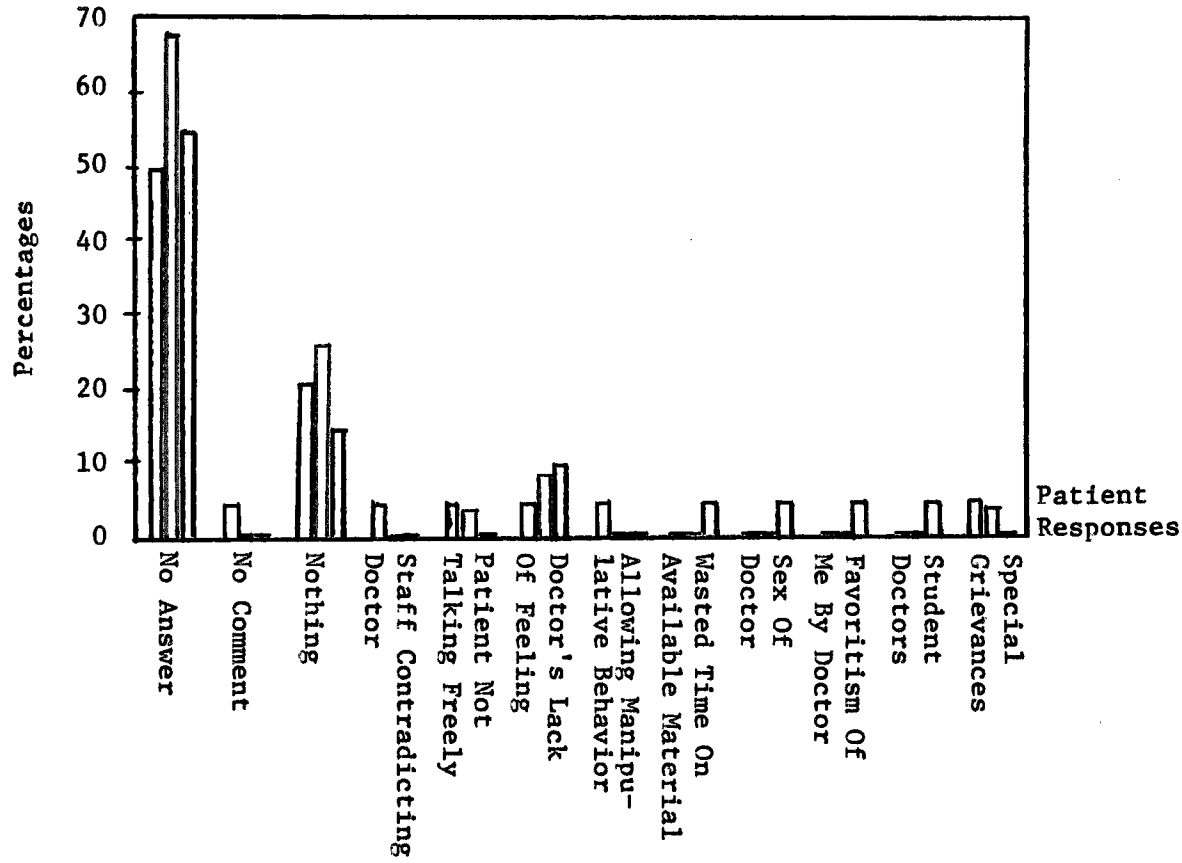
in the area of "what would be more helpful" was "no answer". The third highest percentage of responses in Cottage I was in the areas of "conquering real problem" and "trust and confidence" as being more helpful. In Cottage II the third highest peak indicated that the patients felt that a "warmer response from the doctor" and the doctor's being more "supportive as opposed to nondirective" would be more helpful in the therapeutic relationship. Individual responses were given only by Unit A patients in the area of "no comment" and doctor's being "more supportive not authoritarian".

If the data in regard to "what would be more helpful?" is carefully observed, one striking difference can be recognized between the units. In Cottage II fifteen out of twenty patients, or 75 per cent, gave one of the four following responses: "more supportive as opposed to nondirective", "warmer response", "more time with doctor" and "doctor's being more available". All four of these responses relate to the patients' need to feel that the therapist cares for them. In Cottage I only eight out of twenty-three, or 35 per cent, answered in these categories. In Unit A only six out of nineteen, or 32 per cent, answered in these categories.

What Has Not Been Helpful To You?--In response to this question the two peak responses were in the same area in all three units as revealed in Figure 3. The largest percentage of responses was in the "no answer" category: 50 per cent on Unit A, 68 per cent in Cottage I and 35 per cent in Cottage II. The second highest peak for all three units was in the "nothing" category: 21 per cent on Unit A, 27 per cent in

Figure 3 - Individual Therapy

What Has Not Been Helpful?



Key - Units

Unit A ☐ N = 19

Cottage I ☐ N = 23

Cottage II ☐ N = 20

Special Grievances

Not Meeting With Social Worker And Family

Financial Difficulties

Cottage I and 15 per cent in Cottage II. Both of these responses, but more specifically "no answer", indicate the possibility that this question might have presented a threat to the respondents. Patients in all three Units mentioned the "doctor's lack of feeling" as not being helpful. This response indicates the patients need to have the therapist respond as a real person. This corresponds to the responses in which the patients desired a warmer response and that the therapist be more supportive. There were more individual responses given by only one unit in response to this question than to any other question in relation to the individual therapy. For example, on Unit A, there were three individual responses--"staff-doctor contradiction", "allowing manipulative behavior" and "no comment". Cottage I had no individual responses unique to its unit whereas Cottage II patients gave four singular responses: "favoritism by doctor", "sex of doctor", and "student doctors", and "too much time on available material".

In general, the unit variable is not a determining factor in the patient's overall perspective in regard to his individual therapy except in the area of what might be considered to be more helpful in the therapeutic relationship and here it definitely seems to be a factor.

PERIOD OF TREATMENT

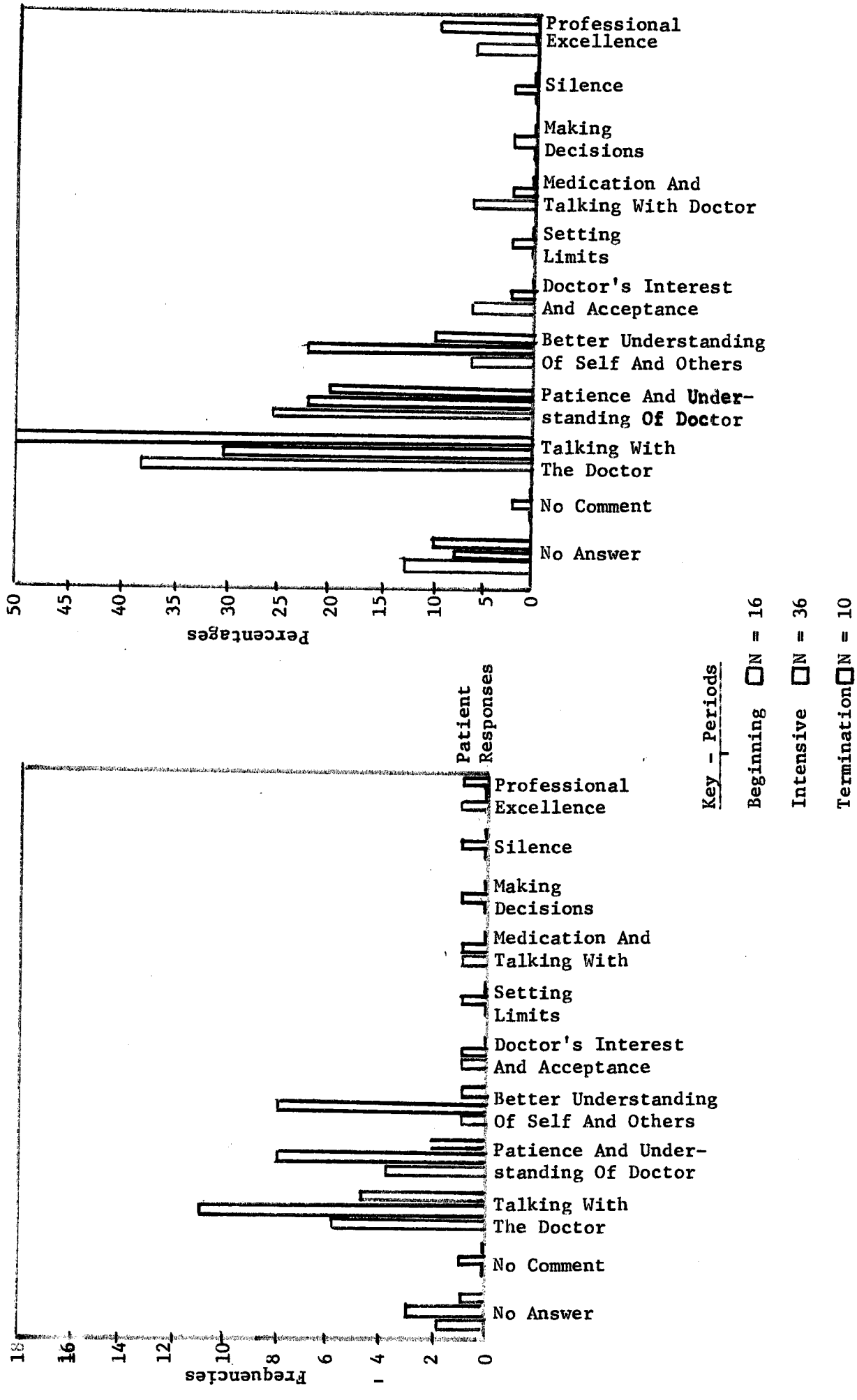
From the results of our study, the patient's period of treatment (beginning, intensive, or termination) does not significantly determine the nature of his response to individual therapy. The highest percentage

of patients in each period said "talking with the doctor" was most helpful and gave "no answer" to the question, "what has not been helpful?" The second highest percentage of patients in each treatment period claimed that the "patience and understanding of the doctor" was most helpful and responded "nothing" to the question "what has not been helpful?" Also in response to the question, "what would be more helpful?" each period has a concentration of responses in the areas of "more time with the doctor" and "no answer". Thus the similarity of responses shows that period of treatment does not effect the greater per cent of responses of patients.

What Has Been Most Helpful To You?--However upon closer observation of the data, certain differences can be recognized which may indicate that patients in a particular period of treatment may be concerned with some aspects of the relationship which patients in another period are not. For example, Figure 4 indicates that eight patients in the intensive period said the most helpful aspect of the relationship was their "better understanding of self and others"and the doctor's "patience and understanding". During the intensive period a patient tends to be most involved in self-understanding, self-awareness. They are involved in a discovery of self and the dynamics of self as it interacts with others. It was also a patient in the intensive period who stated that the doctor's "setting limits" was most helpful; another gave the response of "making my own decisions". These patients had become aware of both their problems and their needs. It was difficult for the first patient to accept limits and yet this patient had the insight to know his need of them.

Figure 4 - Individual Therapy

What Has Been Most Helpful?



"Professional excellence", an area staff is usually quite concerned about, held little significance for patients. The relationship to a patient supersedes any professional qualifications in the eyes of the patient. The latter is important as a quality of the therapist, but does not reflect a major patient concern according to our data. Only patients in the beginning and terminating period gave this response. Initially a patient is looking for a trained person who can really help. The terminating patient may look back and become aware and appreciate the professional excellence of therapists. In the intensive period the patient is more introspective and is concerned with the doctor's concern and understanding of him. Professional excellence is a more objective quality of the therapist and the person just entering into a relationship or preparing to leave one because of renewed ego strength may tend to note a more objective quality. The person entering a relationship with the therapist needs professional excellence--something strong to protect him and hold the patient together. The patient leaving the relationship respects the professional excellence not because he now needs it but because it has brought him to the point of not needing it (i.e. being more self-sufficient).

The "doctor's interest and acceptance" was not mentioned by terminating patients but was by both beginning and intensive periods' patients. When a patient becomes an inpatient, usually his self-esteem, self-image and self-acceptance are very low. He desperately needs someone to accept him. As he struggles through the intensive period, he is dealing with coming to accept self and to use self.

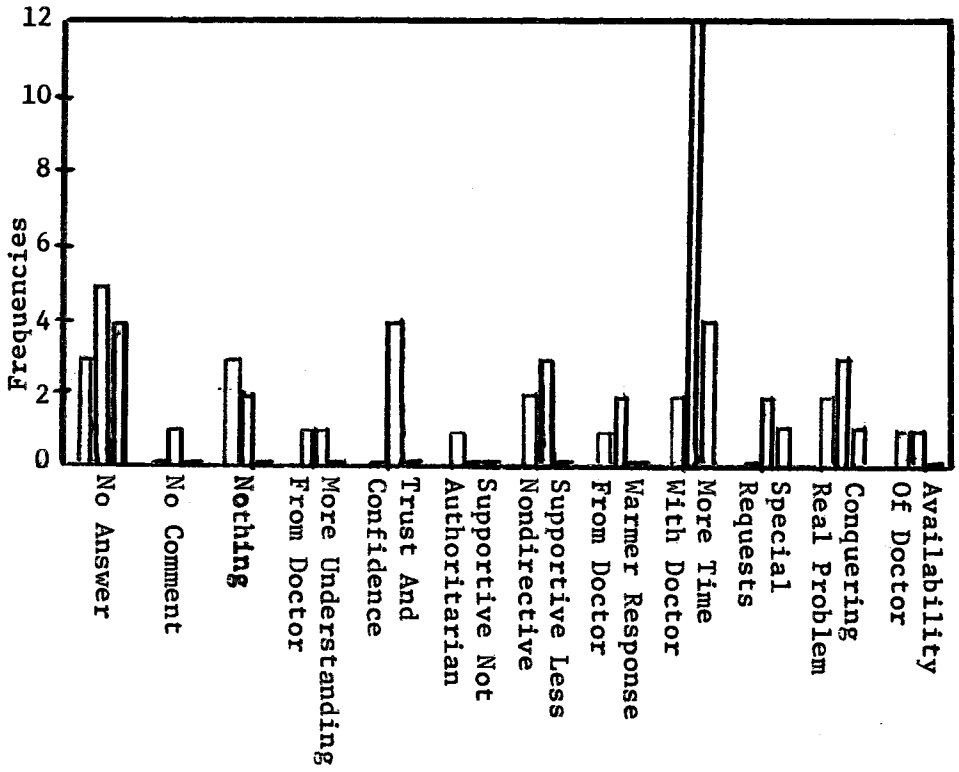
He needs the doctor's acceptance of him as a constant reminder that he is worth accepting. By the time of termination, a degree of self-acceptance has been achieved and the patient having more resources for support within himself tends to be less dependent on the doctor's acceptance.

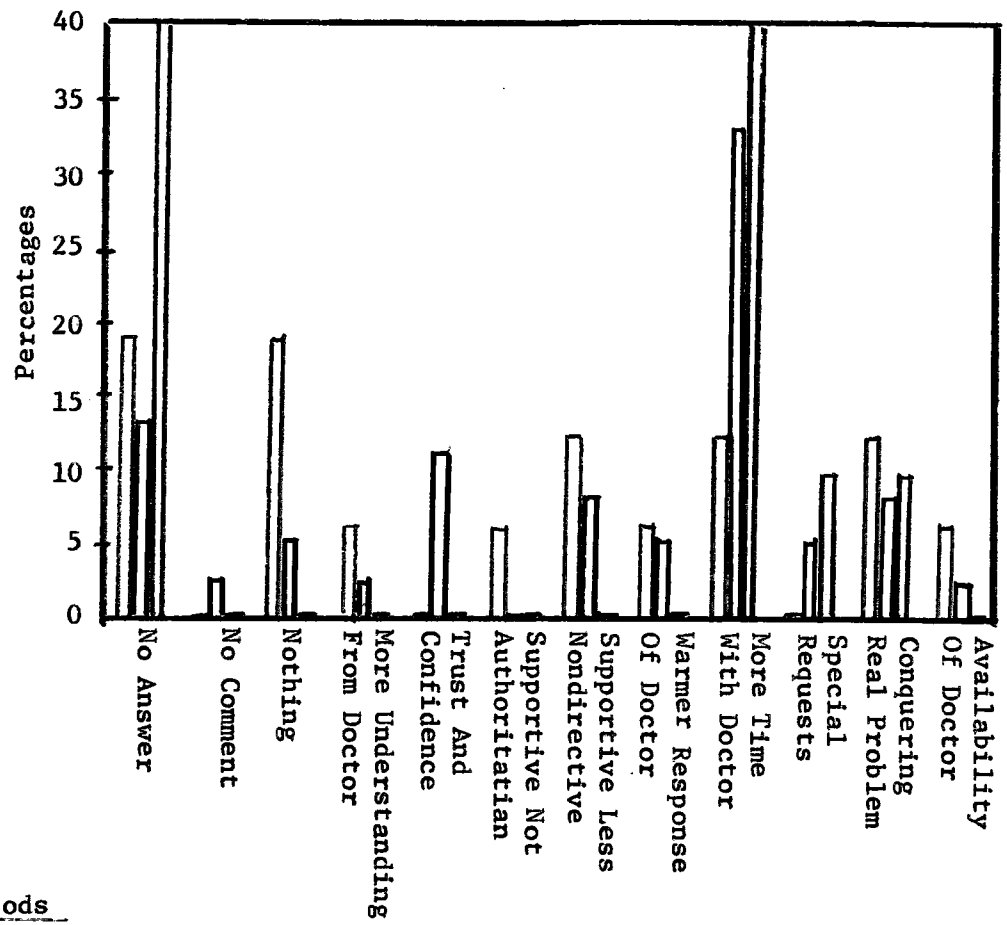
What Would Be More Helpful To You?--Similar to the need for acceptance, patients only in the intensive and beginning periods said that "more support", a "warmer response from the doctor" and the "doctor's being more available" would improve the relationship and be more helpful to them. Figure 5 shows that patients need support as they venture into a relationship and they need constant support of their strengths during the uncovering process and because they often have feelings of weakness and being disintegrated. Patients need to feel that their therapists are persons who care about them and have some faith in their capacity to regain adequate functioning. This will be discussed more extensively in the final chapter.

What Has Not Been Helpful To You?--In relation to this question most answers fell into the "nothing" or "no answer" category as illustrated in Figure 6. Fifty per cent or above in each period gave "no answer" which shows a noncommitted state and the threatening quality of this question. Beyond these responses were several responses given only by individuals in one of the periods. For example, "sex of doctor" and "too much time on available material" were responses given only by patients in the beginning period of treatment. The latter is a rather petty response but does indicate perhaps the need for securing available collateral material so that a patient does not have to start

Figure 5 - Individual Therapy

What Would Be More Helpful?





Special Requests:

Patient-Family Interview With Social Worker

Becoming A Night Patient

More Medication

Key - Periods

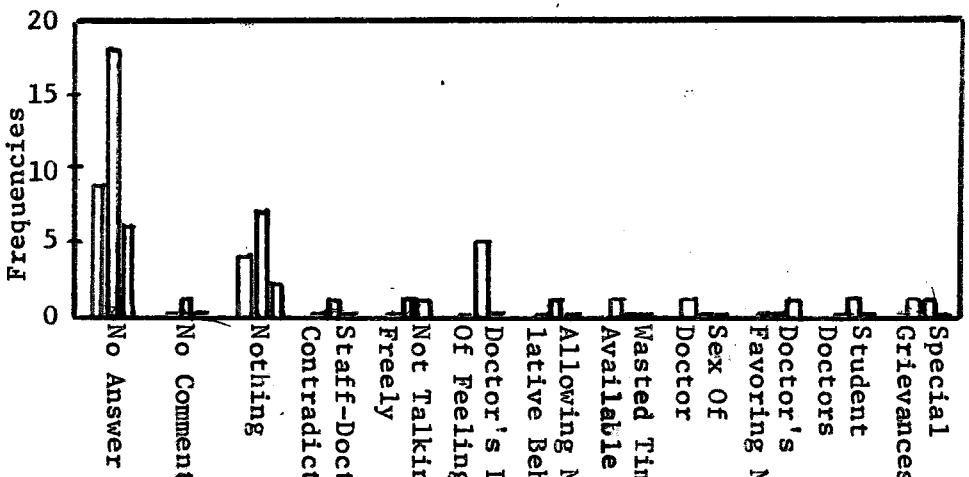
Beginning ☐ N = 16

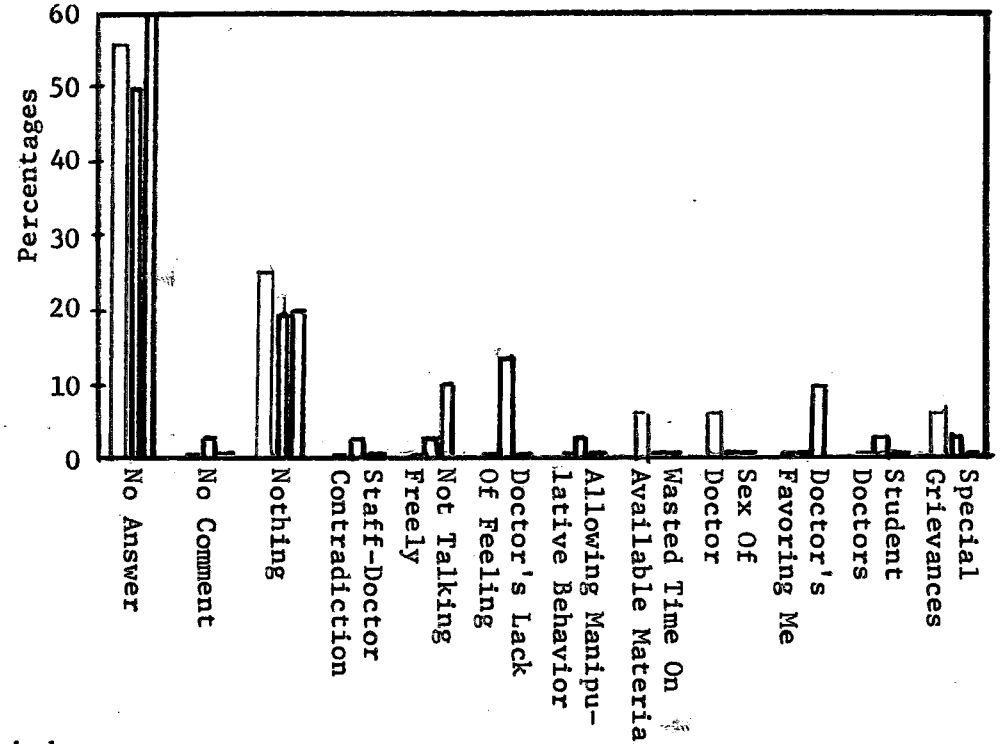
Intensive ☐ N = 36

Termination ☐ N = 10

Figure 6 - Individual Therapy

What Has Not Been Helpful?





Special Grievances:

Not Meeting With Social Worker And Family

Financial Difficulties

Key - Periods

Beginning ☐ N = 16

Intensive ☐ N = 36

Termination ☐ N = 10

from scratch when he enters the Institute after having seen another doctor or having been transferred from a private hospital. Initially the "sex of the doctor" may make a difference to the patient. This may continue to present a problem throughout treatment, but usually the conflict can be worked through as a part of the therapy and becomes less of an issue for the patient.

In the intensive period 15 per cent of the patients said the "doctor's lack of feeling" had not been helpful. This corresponds to the suggestions that a "warmer response" and "supportive approach" would be more helpful. This group is saying they want their doctor to be a person with them and less of a professional automaton. A patient needs to feel that a human being can care for him before he can care for himself. Where there is a great deal of professional distance, this caring of the doctor for his patient is not as easily perceived by the patient or is perhaps mistakenly perceived as "he cares because it is his professional duty to do so".

This response "doctor's lack of feeling" was not given by either beginning or terminating patients. Beginning patients either may not be far enough into the relationship to have passed the superficial level of caring or they feel the doctor does care. The intensive period patient often experiences during this period "being tested by the doctor" or the doctor may purposefully make the patient angry. This may be one reason why the intensive patient uniquely expressed this feeling. In the beginning of a relationship the doctor is primarily building a relationship and a trust. Once he has done

this he is able to use techniques which may make a patient anxious or angry so that problems may be dealt with first-hand. Transference factors may well be involved in patients' feeling a doctor doesn't care. The doctor may withdraw some support in order that a patient must face his problem squarely. This is a touchy area. A few truly skilled persons will support the individual's strength to cope as they push the patient to gain insight. These strengths need to be supported all the way through therapy. Sometimes support is lost in the drive to get a patient to uncover material or develop insight.

The terminating patient is not as dependent on the doctor for constant emotional feeding. Many of the conflicts and transference elements have been worked through and the patient may realize that his doctor does care about him. The doctor is often very supportive of the terminating patient who with his new level of functioning is ready to begin to move back into the mainstream of life. There are many factors which may be involved in this type of response. One that should not be totally neglected is that the therapist has human feelings and in the long and often difficult haul of the intensive period, he or she may become irritated, discouraged and a little rejecting of the patient at times.

DIAGNOSIS

Diagnosis, from our study, cannot be considered a significant variable in determining or characterizing patient responses to individual therapy.

What Has Been Most Helpful To You?--An examination of Figure 7 reveals that the highest peaks of responses of schizophrenic and depressed patients tended to be similar. The most helpful aspect of the one-to-one therapeutic relationship for schizophrenic and depressed patients was "talking with the doctor". For schizophrenic patients the response receiving the second highest frequency was "patience and understanding of the doctor". For depressed patients the second highest frequency was bimodal--"better understanding of self and others" and "patience and understanding of the doctor". This "better understanding" response had the third highest frequency for schizophrenic patients. The schizophrenic patient has symptoms of withdrawal and often has a low level of awareness. Because of the present fear prevalent in psychiatric circles of doing intensive uncovering therapy with a schizophrenic a high level of self-awareness or insight is not expected of schizophrenic patients. It is a compliment to the therapists that at least two schizophrenics felt they had better understanding. Perhaps it also indicates the possibility that a schizophrenic can tolerate more than the literature currently credits him.

What Would Be More Helpful To You?--Both the schizophrenic patients and the depressed patients thought "more time with the doctor" would be more helpful to the one-to-one relationship. Figure 8 illustrates that this was the most frequently given response.

What Has Not Been Helpful To You?--In response to this question, the "no answer" category and "nothing" (i.e. everything is helpful to

Figure 7 - Individual Therapy

Diagnosis Variable - What Has Been Most Helpful?

Patient Responses	Schiz.		Dep.		A.A.R.		Sociopath		Phobic		Anx. Reac.	
	f	%	f	%	f	%	f	%	f	%	f	%
Talking With Doctor	7	36. 8	12	35.3	1	25	0	0	0	0	2	100
Patience And Understanding Of The Doctor	5	26.3	7	20.6	1	25	0	0	2	100	0	0
Better Understanding Of Self And Others	2	10.5	7	20.6	1	25	0	0	0	0	0	0
Doctor's Interest And Acceptance	1	5.3	0	0	0	0	0	0	0	0	0	0
Setting Limits	0	0	0	0	0	0	1	100	0	0	0	0
Medication And Talking With The Doctor	1	5.3	1	2.9	0	0	0	0	0	0	0	0
Making Decisions	1	5.3	0	0	0	0	0	0	0	0	0	0
Silence	1	5.3	0	0	0	0	0	0	0	0	0	0
Professional Excellence	0	0	2	5.9	0	0	0	0	0	0	0	0
No Comment	0	0	1	2.9	0	0	0	0	0	0	0	0
No Answer	1	5.3	4	11.8	1	25	0	0	0	0	0	0
	N = 19		N = 34		N = 4		N = 1		N = 2		N = 2	

Key

Schiz. = Schizophrenia

Dep. = Depressed

A.A.R. = Adolescent Adjustment Reaction

Anx. Reac. = Anxiety Reaction

Figure 8 - Individual Therapy

Diagnosis Variable - What Would Be More Helpful?

Patient Responses	Schiz.		Dep.		A.A.R.		Sociopath		Phobic		Anx. Reac.	
	f	%	f	%	f	%	f	%	f	%	f	%
More Understanding	2	10.5	1	2.9	0	00	0	0	0	0	0	0
Trust And Confidence	2	10.5	2	5.9	0	0	0	0	0	0	0	0
Supportive-Not Authoritarian	1	5.3	0	0	0	0	0	0	0	0	0	0
Supportive - Less Nondirective	1	5.3	1	2.9	1	25	0	0	0	0	1	50
Warmer Response From Doctor	0	0	3	8.8	0	0	0	0	0	0	0	0
More Time With The Doctor	7	36.8	8	23.5	1	25	0	0	1	50	1	50
Special Requests	1	5.3	2	5.9	0	0	0	0	0	0	0	0
Conquering Real Problem	1	5.3	3	8.8	1	25	0	0	1	50	0	0
Availability Of Doctor	0	0	1	2.9	1	25	0	0	0	0	0	0
No Comment	0	0	1	2.9	0	0	0	0	0	0	0	0
Nothing	1	5.3	4	11.8	0	0	0	0	0	0	0	0
No Answer	3	15.8	8	23.5	0	0	1	100	0	0	0	0
	N = 19		N = 34		N = 4		N = 1		N = 2		N = 2	

Key - Diagnosis

Schiz. = Schizophrenia

Dep. = Depressed

A. A. R. = Adolescent Adjustment Reaction

Anx. Reac. = Anxiety Reaction

Special Requests:

Patient-Family Interview With Social Worker

Becoming A Night Patient

More Medication

some degree) had the highest frequencies for both as shown in Figure 9. The only specific complaint given by both was "doctor's lack of feeling". This category had the third highest frequencies for both diagnostic categories.

SUMMARY OF THE RESPONSES OF PATIENTS WITH ADOLESCENT ADJUSTMENT REACTION, PHOBIC REACTION, ANXIETY REACTION AND SOCIOPATHIC PERSONALITY CONCERNING INDIVIDUAL THERAPY.--As for those patients diagnosed with adolescent adjustment reaction there was such a small sample (four) that little can be concluded. Besides the small sample the four answers are split one-one-one-one, two-two or two-one-one. "What has not been helpful?" has the only three-one split. Three adolescents didn't answer, and one said that "doctor's lack of feeling" had not been helpful. There were only two patients diagnosed as phobics and two with anxiety reactions, both samples of which are too small to allow for significant findings. The phobic found the "patience and understanding of the doctor" most helpful and desired "more time with the doctor" and "conquering real problem". The two patients with anxiety reactions thought "talking with the doctor" the most beneficial aspect of individual therapy but desired "more time with the doctor" and "more participation (less nondirective) approach".

There was only one sociopath in our sample. To this patient the most helpful aspect was the doctor's "setting limits" and the least helpful was the doctor's "allowing his manipulative behavior". These were very honest answers as this patient is aware he needs limits yet his most frequent immediate response to limits is to rebel

Figure 9 - Individual Therapy

Diagnosis Variable - What Hat Not Been Helpful?

Patient Responses	Schiz.		Dep.		A.A.R.		Sociopath		Phobic		Anx. Reac.	
	f	%	f	%	f	%	f	%	f	%	f	%
Staff-Doctor Contradiction	0	0	1	2.9	0	0	0	0	0	0	0	0
Not Talking Freely	2	10.5	0	0	0	0	0	0	0	0	0	0
Doctor's Lack Of Feeling	2	10.5	2	5.9	1	25	0	0	0	0	0	0
Allowing My Manipulative Behavior	0	0	0	0	0	0	1	100	0	0	0	0
Wasted Time On Available Material	0	0	1	2.9	0	0	0	0	0	0	0	0
Sex Of Doctor	0	0	1	2.9	0	0	0	0	0	0	0	0
Doctor's Favoring Me	0	0	1	2.9	0	0	0	0	0	0	0	0
Student Doctors	1	5.3	0	0	0	0	0	0	0	0	0	0
Special Grievances	1	5.3	1	2.9	0	0	0	0	0	0	0	0
Nothing	5	26.3	7	20.6	0	0	0	0	1	50	0	0
No Comment	0	0	0	2.9	0	0	0	0	0	0	0	0
No Answer	8	42.1	19	55.9	3	75	0	0	1	50	2	100
	N = 19		N = 34		N = 4		N = 1		N = 2		N = 2	

Key - Diagnosis

Schiz. = Schizophrenia

Dep. = Depressed

A.A.R. = Adolescent Adjustment Reaction

Anx. Reac. = Anxiety Reaction

Special Grievances:

Not Meeting With Social Worker And Family

Financial Difficulties

against them or manipulate around them.

SEX

From the data collected, sex, like diagnosis, does not appear to be a significant variable in determining patients' responses to the questions regarding their one-to-one relationship with their therapist.

What Has Been Most Helpful To You?--Figure 10 indicates that in response to this question the highest frequency of responses of patients of both sexes was "talking with the doctor". The second highest number of males and females claimed the "patience and understanding" of the doctor was most helpful. "Better understanding of self and others" tied for second place among the females and came in third among the males.

What Would Be More Helpful To You?--One problem or limitation in comparing the sexes involves the sizes of the samples (sixteen males and forty-six females). This disparity in number of males and females does not lend itself to an accurate comparison. In suggesting what would be more helpful the highest frequency of males and females said "more time with doctor". This involved 28 per cent or fifteen of the females and 31 per cent but only five males as shown in Figure 11. Thus the frequency of females is higher but the percentage of males is higher. For this reason, the researchers are comparing both sexes by high peaks of responses on the graph rather than comparing the actual percentages or frequencies. The percentage of patients of

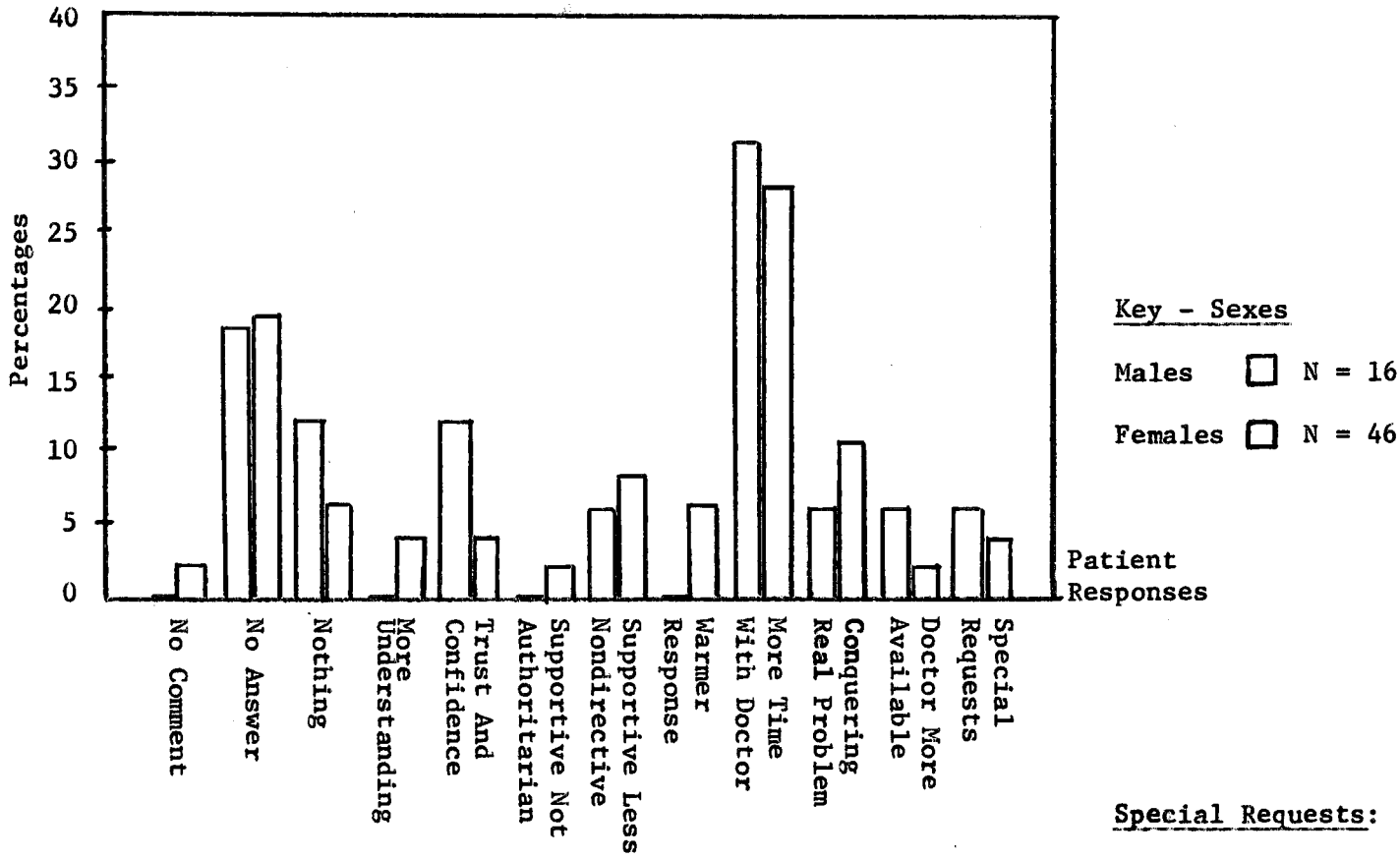
Figure 10 - Individual Therapy

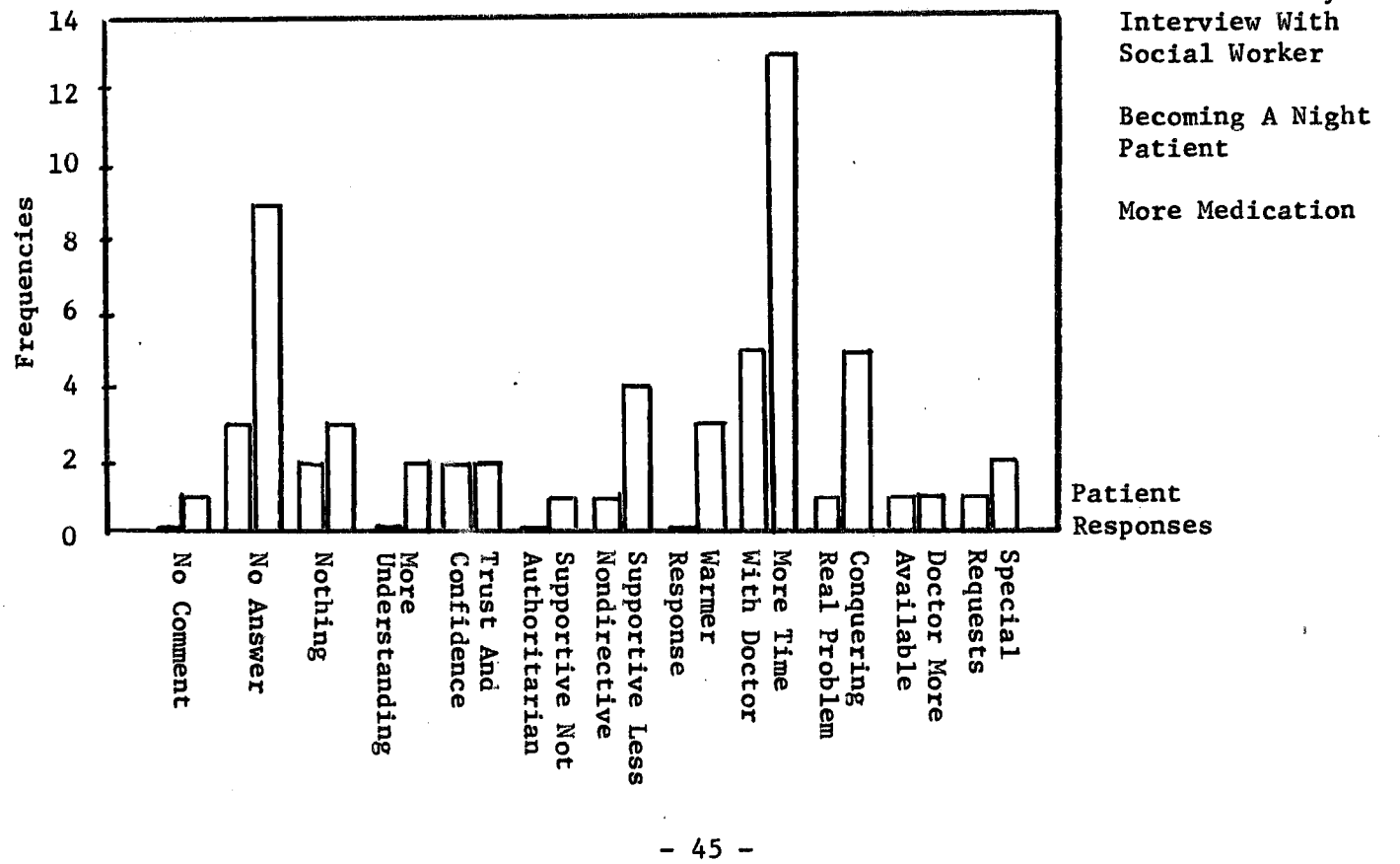
Sex Variable - What Has Been Most Helpful?

Patient Responses	Males		Females	
	f	%	f	%
Talking With Doctor	6	37.5	16	34.8
Patience And Understanding Of Doctor	3	18.6	11	23.9
Better Understanding Of Self And Others	3	18.6	7	16.1
Doctor's Interest And Acceptance	1	6.3	1	2.3
Setting Limits	1	6.3	0	0
Medication And Talking With Doctor	1	6.3	1	2.3
Making Decisions	0	0	1	2.3
Silence	0	0	1	2.3
Professional Excellence	1	6.3	1	2.3
No Comment	0	0	1	2.3
No Answer	0	0	6	13
	N = 16		N = 46	

Figure 11 - Individual Therapy

What Would Be More Helpful?





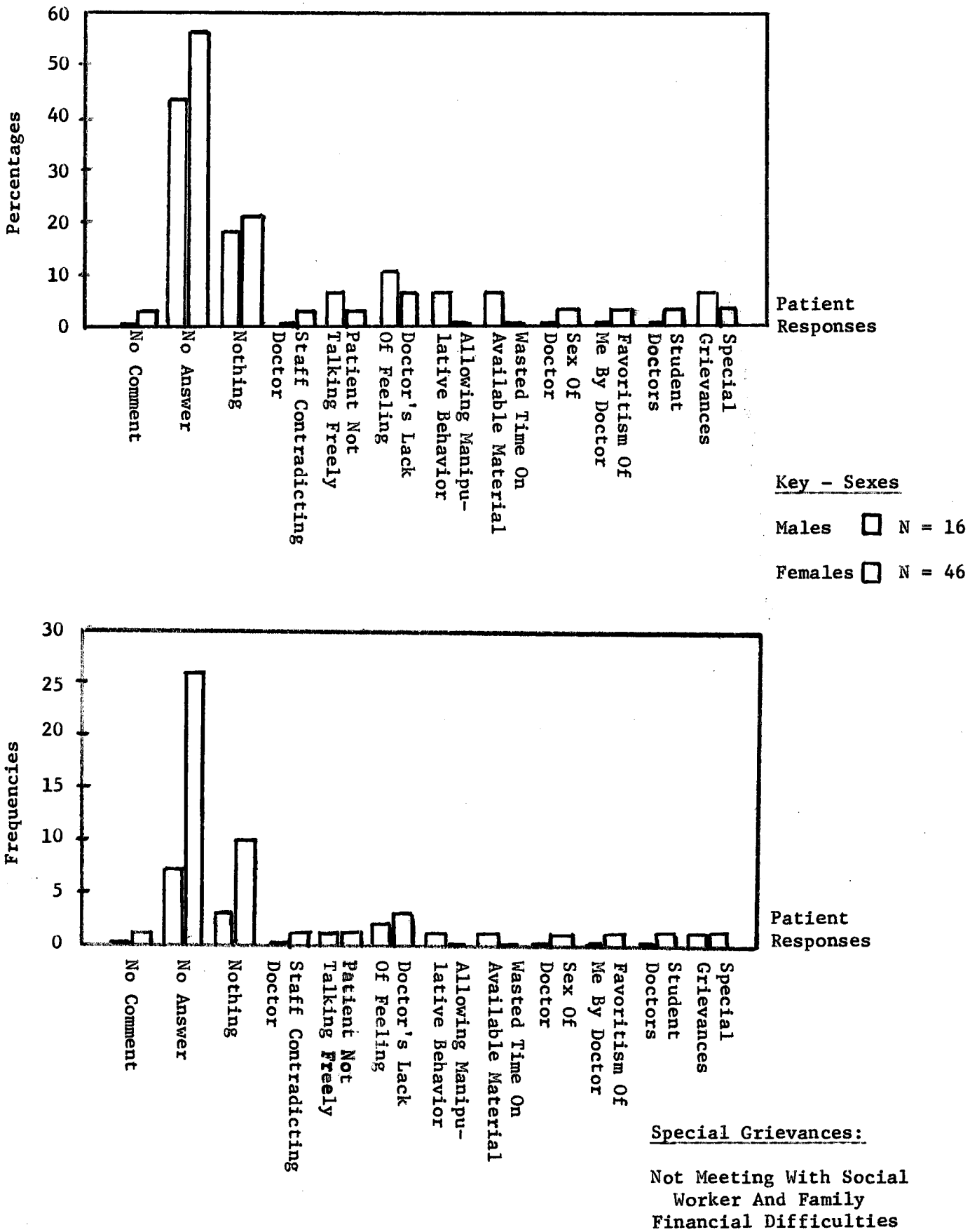
both sexes failed to respond to the question "what would be more helpful?" Figure 12 illustrates that the highest proportion of males and females respectively gave no answer. The second highest proportion of each group said "nothing" (i.e. everything was in some way helpful). The third highest proportion for each sex fell into the response "doctor's lack of feeling". Thus it can be seen that the responses receiving the greater frequencies were the same for the male group and the female group. Therefore sex cannot be interpreted as being a significant factor in determining a patient's feelings about his relationship with his therapist.

However certain differences can be seen in responses receiving less high a frequency. For example only females mentioned "more understanding" and "warmer response" as suggestions for what would be more helpful to their relationship with their therapist. A male's self-image would tend to make him a little more hesitant to give these responses whereas he could feel more comfortable in asking for more "trust and confidence" which he did in this study. Trust and confidence are qualities which a man seeks in his role as businessman, husband and father. Both sexes did mention a desire for a more supportive and less nondirective approach.

In general none of the four variables (unit, period, diagnosis, and sex) tends to make a significant difference in a patient's feelings toward his relationship with his therapist. On the other hand, unit, which the researchers did not think would be significant in relation to individual therapy, did make a difference to the question "what would be more helpful".

Figure 12 - Individual Therapy

What Has Not Been Helpful?



CHAPTER III

ANALYSIS OF DATA: MILIEU THERAPY

QUESTIONS ASKED

Outside of your one-to-one therapy:

1. What has been most helpful during your stay at the Institute?
2. What would be more helpful?
3. What has not been helpful?

UNIT

Description: Unit A is located in the Administration Building of the Institute. The patients who are homicidal, suicidal and elopement risks are housed on this unit. Unit A has the only locked wing as well as a seclusion room. All rooms are single with a connecting one-half bath and there are three community showers. There are two patient lounges for social activities and a dining facility which also serves as a television area.

Cottages I and II are similar in their physical structure and each has rooms which accommodate more than one patient rather than single rooms. They are similar to Unit A in having lounges and a dining facility for their patients.

In all units each patient is assigned to a nurse or psychiatric aide on each daily shift. The patient's involvement with other patients and with the nursing staff on the unit is evaluated and

dealt with according to the patient's individual needs as determined by his principal therapist, according to the nursing staff's observation and evaluation of the patient's behavior and according to the team's observations.

Patient meetings are held in each unit, three times weekly on Unit A and Cottage I and five times weekly in Cottage II. The purpose of these meetings is to help patients deal with problems of group interaction and feelings. These meetings are mandatory in Cottages I and II and patients on Unit A are expected to attend but no follow through is made to encourage or force attendance. Cottages I and II hold community meetings (all patients and staff) once each week to discuss any problem pertaining to the milieu.

As a part of milieu therapy, in Cottage I there are weekly psychodrama sessions, a literary group, weekly art classes, religious discussion groups and the publication of a newspaper. In Cottage II the Wednesday night activity groups meet. At the time of this study these activities had been in operation for two weeks. The patients plan and conduct the activity to be carried out.

The three therapies, occupational, music and recreational, are an important part of milieu therapy and are used by all three units.

Data Analysis: The responses from patients in the three units in regard to milieu therapy have been classified into main categories and subcategories.

What Has Been Most Helpful To You?--Figure 13 reveals that the largest percentage of responses fall into four main categories. Although there

Figure 13 - Milieu Therapy

Unit Variable - What Has Been Most Helpful?

Patient Responses	Unit A		Cottage I		Cottage II	
	f	%	f	%	f	%
Answers Relating To Patients And Self	1	5.3	2	8.7	3	15
Answers Relating To Patients And Staff	3	15.8	4	17.4	2	10
Answers Relating To Staff	4	21.1	9	39.1	7	35
Answers Relating To Atmosphere & Activities	9	49.5	6	26.5	8	40
Miscellaneous Responses	2	10.5	2	8.7	0	0
	N = 19		N = 23		N = 20	

Key - Responses

Answers Relating To Patients And Self
- a. Being With Other Patients
- b. To Know Myself

Answers Relating To Patients And Staff
- a. Friendly Attitude
- b. Forming Close Relationships

Answers Relating To Staff Only
- a. General Attitude And Availability
- b. Supportive Attitude
- c. Efficiency
- d. Talking With Psychiatric Aide

Answers Relating To Atmosphere And Activities
- a. Having A Refuge From Outside Pressure
- b. Singular Responses: Patient Meeting, Thorough Medical Attention, Non-Hospital Atmosphere, Psychological Testing
- c. Vocational Rehabilitation
- d. Occupational Therapy, Music Therapy, Recreational Therapy
- e. Sleep And Rest
- f. Psychodrama

Miscellaneous Responses
- a. No Comment
- b. No Answer

is some similarity among the responses from all three units, there is a difference between the units as to the areas of most significance. For example, the peak response to this question on Unit A and Cottage II was in relation to "atmosphere and activities". Under this main category, the majority of patients responding in this area gave the answer that "occupational therapy, music therapy and recreational therapy" had been most helpful to them in their life on the unit. These activities are an important aspect of the total therapeutic process. The patients perceived it as such and not just as a means of occupying time.

In Cottage I the peak response to the question, "what had been most helpful?", was in "answers relating to staff". Of the nine patients who answered in this main category, five patients felt that the "general attitude and availability of staff" had been most helpful and two responded that the "supportive attitude of staff" had been most helpful.

The second highest peak response for Unit A and Cottage II was in the main category of "answers relating to staff". The majority of patients answering in the category on Unit A felt the "supportive attitude of staff" was most helpful and "general attitude and availability of staff" was given by the second largest number of patients. In Cottage II the same responses were given but in reverse order.

In Cottage I, the second highest peak response was in "answers relating to atmosphere and activities". The most important area for

those patients whose responses fell in this category was "psychodrama". Significantly, Cottage I was the only unit in which psychodrama was being used at the time this study was done. Those patients who had been exposed to this media possibly felt that this was an area in which they could really begin to see themselves in their interaction with staff and other patients. This was the only group activity receiving only positive responses.

In the main category "answers relating to patients and staff" Unit A and Cottage I patients gave similar responses, "friendly attitude of staff" and "forming close relationships". Cottage II patients failed to answer in the area of "forming close relationships" as being most helpful although two out of three patients answering in "relation to patients and self" felt that "being with other patients" had been most meaningful.

The patient's day to day interaction with staff and other patients is a most significant aspect of the total therapeutic program. Through this interaction, the patients are confronted with the realities of their behavior and how each effects the other. The therapeutic community is but a small segment of the larger society and through this experience in group living patients learn to live with other individuals in a more healthy way. If one observes the responses to the question "what has been most helpful", it is obvious that the patients recognize that through their interaction with other individuals a more healthy self emerges. For example, of the total responses to this question the greatest number of responses in all three units was around relationships with other

individuals rather than the more tangible aspects of atmosphere and activity. The subcategories relating to the intangibles of a relationship are: "being with other patients", "friendly attitude of staff", "forming close relationships", "general attitude and availability of staff", "efficiency of staff" and "talking with the psychiatric aide". Of the nineteen patients on Unit A, eight gave answers relating to personal interaction with other individuals, fifteen out of twenty-three in Cottage I and eleven out of twenty in Cottage II gave these answers. Of particular significance, however, is the fact that even though more than 50 per cent of Cottage II patients' responses were centered around the relationship aspect, none felt that "forming close relationships" had been most helpful. This will be discussed more fully in relation to the questions, "what has not been helpful in your life on the unit".

It is also significant to note that there were fewer "no answer" responses to this particular question than to any other. Unit A had only one answer in this category, Cottage I had two and Cottage II had none.

What Would Be More Helpful To You?--Figure 14 reveals that a similarity exists between the three units in their responses to this question. All three units' peak responses were, in descending order: "answers relating to atmosphere and activities", "miscellaneous responses" and "answers relating to staff". There were some differences, however, in the subcategorical responses, particularly in "answers relating to staff". Unit A patients wanted "a unified

Figure 14- Milieu Therapy

Unit Variable - What Would Be More Helpful?

Patient Responses	Unit A		Cottage I		Cottage II	
	f	%	f	%	f	%
Answers Relating To Patients And Self	1	5.3	3	13.04	2	10
Answers Relating To Patients and Staff	1	5.3	0	0	0	0
Answers Relating To Staff	2	10.5	4	17.4	3	15
Answers Relating To Atmosphere & Activities	9	49.5	9	39.1	9	45
Miscellaneous Responses	6	31.6	7	30.4	6	30
	N = 19		N = 23		N = 20	

Key - Responses

Answers Relating To Patients And Self
- a. Taking Better Physical Care Of Self
- b. Being More Patient
- c. Being Happy
- d. Not Running
- e. Being Able To Accept Warm Feelings

Answers Relating To Patients And Staff
- a. More Close Relationships

Answers Relating To Staff Only
- a. A Unified Approach
- b. Larger Staff For Better Individual Care
- c. More Structuring
- d. Help Me To Talk
- e. Nurse's Giving Simple Medications Without Doctor's Order
- f. More Attention

Answers Relating To Atmosphere And Activities
- a. More Spare Time Activities
- b. Freedom Not To Participate
- c. Consideration For Sleep And Rest
- d. Weekend Activities
- e. More Psychodrama
- f. More Family Therapy
- g. More Intensive Vocational Rehabilitation Counseling
- h. To Be Made To Feel More Like A Patient Than A College Student,
- i. Special Requests: Patient Library On The Unit, A Truly Quiet Area, Getting Outdoors More, Discussion Topics For Patient Meetings, More Flexibility in Daily Schedules

Miscellaneous Responses
- a. Nothing
- b. No Comment
- c. No Answer

approach among staff" and a "larger staff". Cottage I patients answered "structuring", "helping me to talk", "staff wouldn't talk" and "more attention". Cottage II patients answered "helping me to talk", "nurse's giving simple medications" and "more attention".

In "answers relating to activities and atmosphere" all three units had patients' desiring "more spare time activities" and "more weekend activities". Even though there are planned activities in all units, all patients do not participate nor are there activities on the weekends when fewer patients remain at the hospital and fewer staff are present to organize activities. In this general category, Cottage I patients felt more "psychodrama" and "more family therapy" would be more helpful. Both of these responses were given by Cottage I only.

In relation to the question, "what would be more helpful", there were special requests made by Unit A and Cottage II patients which might be considered important although each was a singular response. These were: (1) a unit library (2) a truly quiet area (3) more flexibility in daily schedule (4) getting outdoors more, and (5) topics for discussion at patient meetings.

Figure 14 shows that the three units were almost identical in the percentage of patients responding in the category of "miscellaneous responses": Unit A, 31 per cent; Cottage I, 30 per cent; and Cottage II, 30 per cent. There was a striking difference in the specific area of responses. On Unit A four out of six patients answered "nothing"; one answered "no comment"

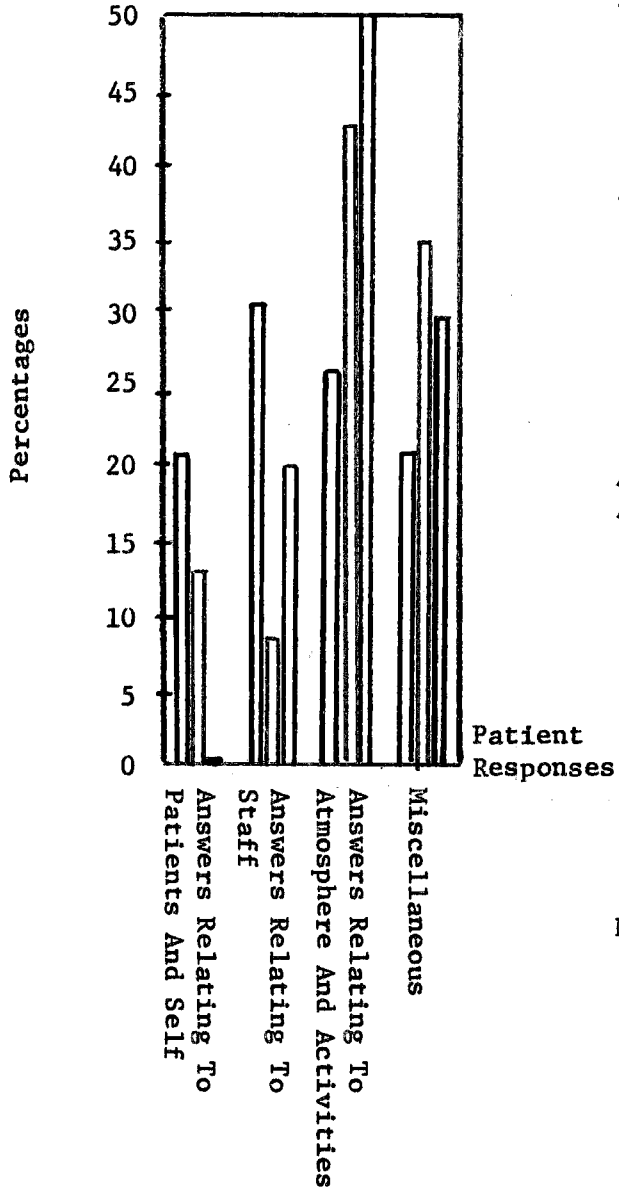
and one gave "no answer". By contrast, in Cottage I, one patient answered "nothing" and six did not respond. In Cottage II, one patient answered "nothing" and six did not respond. Considering the large percentage of patients whose responses were in the "no answer" subcategory, Cottage I, 27 per cent and Cottage II, 25 per cent, the questions might be asked, were these patients so satisfied with the status quo they felt nothing could be improved or did these patients feel it would be more advantageous to be noncommittal? One can only speculate that if the former was true, then would these patients not have answered "nothing" rather than failing to respond? The Unit A patients knew the researchers who were staff members on their unit. For this reason, they may have trusted the researchers more and been less afraid of repercussions resulting from their criticisms or suggestions.

What Has Not Been Helpful To You?--In milieu therapy, Figure 15 reveals that the unit variable appears to make a difference in the patients' responses to the question, "what has not been helpful?", particularly in the responses which dealt with staff-patient or patient-patient interaction.

On Unit A, the largest percentage of responses was in the main category "answers relating to staff". Of the six patients responding in this category, two answered "argumentative staff", two answered "obtrusive staff" and one in each of the subcategories "staff-doctor contradiction" and "staff allowing manipulative behavior". Each of these responses indicates that emotionally

Figure 15 - Milieu Therapy

What Has Not Been Helpful?



Key - Responses

Answers Relating To Patients And Self
- a. Disruptive Patients
- b. Worrying
- c. Feeling Must Participate
- d. Not Seeing My Children

Answers Relating To Staff
- a. Staff Contradicting Doctor
- b. Argumentative Staff
- c. Obtrusive Staff
- d. Lack Of Close Relationships
- e. Staff Allowing My Manipulative Behavior
- f. Service Of Psychiatric Aide

Answers Relating To Atmosphere And Activities
- a. Occupational Therapy And Music Therapy
- b. Individual Complaints: Talking To So Many People In Evaluation, Noise, Experience With Vocational Rehabilitation Not Helpful, Inflexibility Of Schedules
- c. Patient Meetings
- d. No Weekend Activities
- e. Too Much Spare Time
- f. Wednesday Night Activities

Miscellaneous Responses
- a. Nothing
- b. No Comment
- c. No Answer

Key - Units

Unit A ☐ N = 19

Cottage I ☐ N = 23

Cottage II ☐ N = 20

disturbed patients do have an awareness of the lack of cohesiveness among staff as well as how staff is responding to them. This awareness is not projection as there was some lack of unity among the staff on Unit A which later was recognized by the staff itself. By contrast, Cottage I had only 9 per cent or two patients whose responses fell within this main category of "answers relating to staff". In Cottage II, 20 per cent of the patients or the third highest number in this unit, answered in this same category "answers relating to staff". Of these, three out of four answered that "lack of close relationships" had not been helpful. This corresponds to the fact that "forming close relationships" was not given by patients in Cottage II in response to "what had been most helpful?" This same need was also detected in their responses to the question regarding "what would be more helpful" in the one-to-one relationship. Here the answers "warmer response", "availability of doctor", and "supportive, not nondirective", indicate the patients' desire for closer relationships. It is also possible that there might have been an overly dependent relationship existing between staff and patients, hence the need to be continuously given to. However, if this were true, it would seem that some of these patients would have answered that "forming close relationships" had been helpful. One might also speculate around the possibilities of conflict among the staff. Staff members in their struggle for status on the unit may be keeping the patients at a distance, thus not allowing for the development of a close relationship.

In response to the question "what had not been helpful?",

"answers relating to atmosphere and activities" received the largest percentage of the responses in Cottage I and Cottage II: Cottage I, 54 per cent; and Cottage II, 50 per cent. Unit A had 27 per cent responding in this category. In this main category group activities received the largest percentage of negative responses. On Unit A two out of five patients felt that "patient meetings" had not been helpful as compared with five out of ten in Cottage I. The patient meeting is the media in which patients deal with their interaction and feelings in the group situation. All are not able to tolerate this exposure and feel their unique individual problems should be dealt with only in their one-to-one therapeutic relationship. No patient in Cottage II gave a negative response to patient meetings in spite of the fact such meetings are held daily. This may be due to the fact that the patients are satisfied with patient meetings as they now are. If this is true, it would be interesting to know if patient meetings in Cottage II are handled differently from the way they are handled on Unit A and Cottage I.

In this same area of group activities four out of ten patients in Cottage II answered that the "Wednesday night activities" had not been helpful. This activity had been in operation for only two weeks and there had been little opportunity for the patients to observe positive results in so short a time. In addition, the patients decide and plan the activity to be carried out. The newness of this group experience and the possibility that the patients were uncertain as to expectations could also account for the many negative responses received.

Patients in all three units mentioned "occupational therapy and music therapy" as not being helpful. Unit A had the largest number of patients responding in this subcategory, two out of five, as compared with one out of ten in Cottage I and two out of ten in Cottage II. This may be due in part to the fact that these activities are usually carried out in Cottage VI which is more easily accessible to Cottages I and II than to Unit A. It can also be speculated that the therapeutic qualities of these activities had not been recognized by these patients. These activities might have been viewed as being the equivalents of art and music in high school, that is, being of little significance. These patients might also have felt that these activities required talent which they did not possess; therefore, they lacked the self-confidence to enjoy participation in them.

The second highest peak response to the question, "what has not been helpful?" for Cottage I and Cottage II was in the main category "miscellaneous responses". On Unit A, this category tied with "answers relating to patients and self" as being the third highest percentage of responses. Regarding milieu therapy this question was not as threatening as it was regarding individual therapy. Only one patient in Unit A gave no answer while five out of eight in Cottage I and four out of six in Cottage II gave no answer. In the "nothing" subcategory which is viewed as the positive response, Unit A had two patients giving this response, Cottage I had three and Cottage II had two.

Figure 15 reveals that a difference between the units was seen in the patients' giving "answers relating to patients and self". Unit A had 21 per cent of its patients answering in this category and three out of four stated that "disruptive patients" had not been helpful. This response seems appropriate to this unit where the more disturbed patients are treated; hence, there is likely to be more overt acting out behavior exhibited. Cottage I had 13 per cent of its patients responding in this main category with the responses equally divided between "disruptive patients", "worrying" and "feeling must participate". Cottage II had no patients to answer in this category.

In general, the data indicates that there are similarities as well as differences between the units in the patients' evaluation of the milieu therapy. The responses in all three units, particularly in relation to "what has been most helpful", were similar in that the patients perceived their relationship with other individuals whether staff or other patients as being more important in their life on the unit. Patients in each unit requested "more spare time activities" and "weekend activities". There were also similarities in regard to activities which were considered helpful. The units differed in regard to "patient meetings", "psychodrama", "Wednesday night activities", "staff-doctor contradiction", "unified approach of staff", "lack of close relationships", "argumentative staff", "need for larger staff" and in "special requests" for what would be helpful to improve

the atmosphere on the units.

PERIOD OF TREATMENT

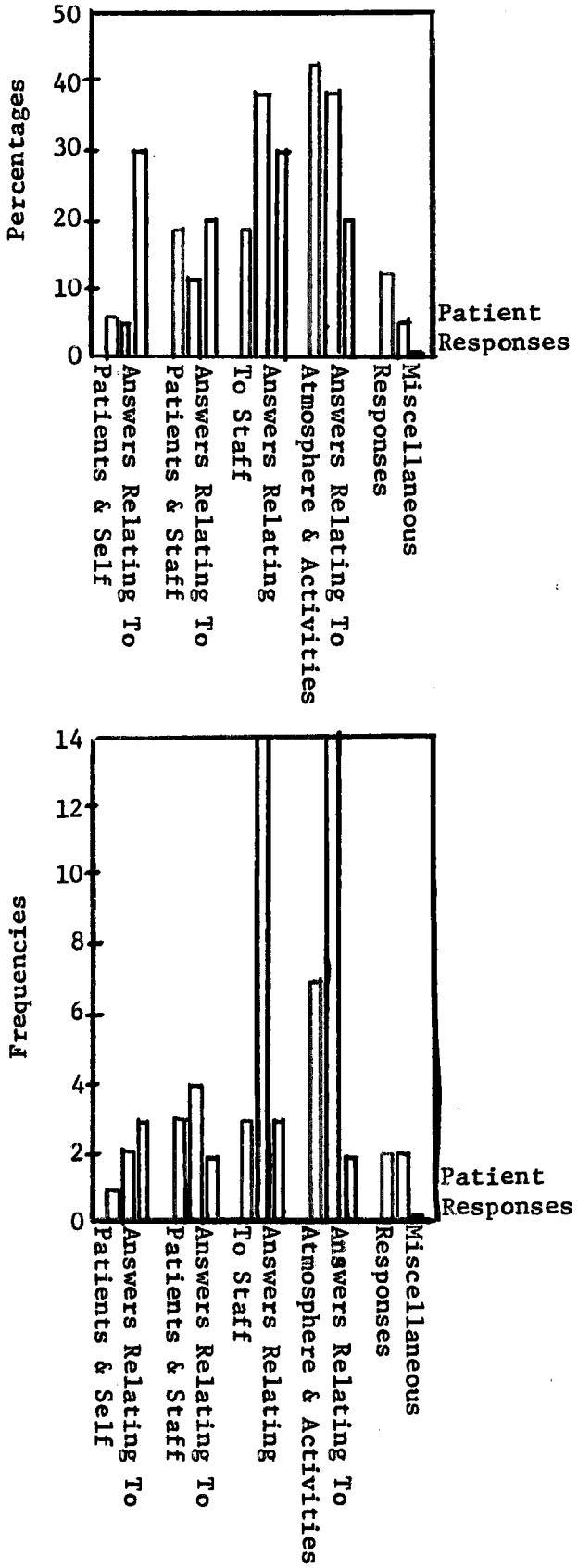
The different samples of each period are not equal. There were on November 21, 1966, only sixteen patients in the beginning period of treatment. In the intensive period there were thirty-six patients and in the termination period only ten patients. This divergence in sample sizes limits the significance that can be attached to the findings.

What Has Been Most Helpful To You?--Figure 16 reveals that the highest peak, 44 per cent for beginning period, fell in the category of "answers relating to atmosphere and activities". For the intensive period, two categories of answers tied or were bimodal in receiving the highest percentage of responses. Both "answers relating to staff only" and "answers relating to atmosphere and activities" had 39 per cent. For the terminating patients, the responses "answers related to staff only" and "answers relating to patient and self" tied for peak response and were bimodal at 30 per cent.

These findings present an interesting trend. The beginning patient, who has not yet formed strong relationships, usually gives the most objective response. The intensive patient on the whole is slightly more subjective in that the group of answers relating to a "group of persons (the staff)" receives as many responses as the more objective response, "atmosphere and activities".

Figure 16 - Milieu Therapy

What Has Been Most Helpful?



Key - Responses

Answers Relating To Patients And Self
- a. Being With Other Patients
- b. To Know Myself

Answers Relating To Patients And Staff
- a. Friendly Attitude
- b. Forming Close Relationships

Answers Relating To Staff
- a. General Attitude And Availability
- b. Supportive Attitude
- c. Efficiency
- d. Talking With Psychiatric Aide

Answers Relating To Atmosphere And Activities
- a. Singular Responses: Patient Meetings, Thorough Medical Attention, Psychological Testing, Non-Hospital Atmosphere
- b. A Refuge From Outside Pressures
- c. Vocational Rehabilitation
- d. Occupational Therapy, Music Therapy, And Recreational Therapy
- e. Sleep And Rest
- f. Psychodrama

Miscellaneous Responses
- a. No Comment
- b. No Answer

Key - Periods

Beginning ☐N = 16

Intensive ☐N = 36

Termination ☐N = 10

The terminating patient is able to be most subjective and personal in that as many responses fall in the category of "answers relating to patients and self" as in the more objective category of "answers relating to staff". Thus as one moves through therapy, there is a movement from the most objective category towards the most subjective category. This trend in some ways corresponds to human growth and development. A child first gains object awareness which includes seeing his mother as separate from himself. These objects are for him to use to fill his needs. This is more like the beginning patient. As the child develops he is first able to relate to his parents. The staff-patient relationship corresponds to the parent-child relationship in that the parent as well as staff member seeks to support the patient's (child's) strengths, to help him develop awareness of self and others, to encourage his dreams and yet to help him see and respond to life realistically. The staff (parent) seeks to help the patient (child) to become more independent. In this relationship the patient (child) is able to give some of himself but requires more of the staff (parent). In the adolescent period particularly the child begins to relate more to his peers and depends less on his parents. This is the stage of the terminating patient. He has more ego supports and therefore is less dependent on the staff and is capable of entering into peer (or patient) relationships where there is a greater sharing of self. Peers give and take on a more equal basis. Also relating to the trend toward more terminating patients mentioning other

patients and self is the fact that when a patient enters the hospital the most threatening things he encounters are himself and the other patients who may express or act out his hidden and feared feelings. As he moves through therapy these become less threatening. Initially many patients need the staff but fear the relationship because the staff member may come to know him and reject him. When the patient discovers that the staff accepts him without judging him, this fear of relating to staff and to people begins to ease.

As for the specific responses it is interesting to note that only beginning and intensive period patients mentioned the supportive attitude and efficiency of staff and only intensive period patients saw their relationship with the psychiatric aide as most helpful. The termination period patients only mentioned general attitude and availability. Six intensive period patients also mentioned this. Once again the specific need for support (and efficiency in itself may make a patient feel well-cared for) are seen in the beginning and intensive period patients and not with terminating patients.

Another interesting response given only by two intensive period and two beginning period patients was that the hospital's acting as a refuge was most helpful.

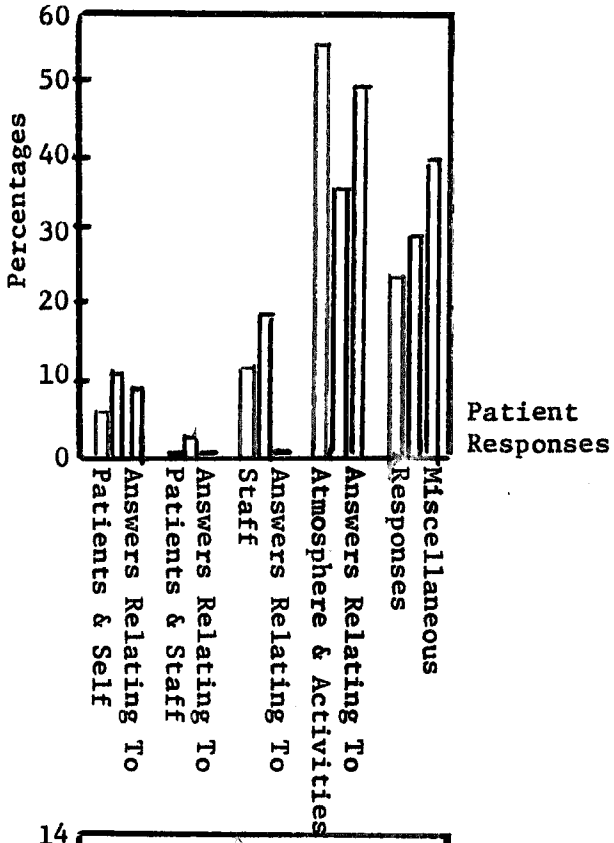
What Would Be More Helpful To You?--In response to this question the highest number and percentage of responses for each period fell into the broad category of answers relating to "atmosphere

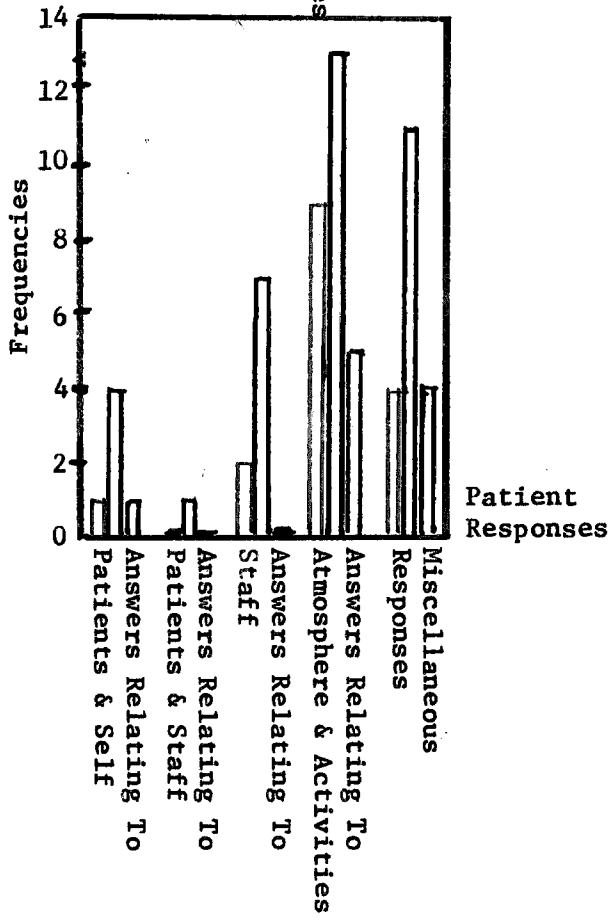
and activities". This question unlike the first introduces a slightly threatening quality because it asks the patient to be critical enough of the situation he is in to be able to offer a constructive suggestion for improvement. Thus as seen in Figure 17 with this question the answers cluster around the "activities and atmosphere" category rather than the categories relating to staff or patients, the categories involving people. It is safer to criticize things than people. The second highest peak for all three periods falls in the "miscellaneous category" and the majority of these responses fell specifically in the "no answer" subcategory.

The intensive period had a higher percentage of responses in both the general category of "answers relating to patients and self" and that of "answers relating to staff only" than either of the other two periods' responses to "what would be more helpful?" The intensive period patient has been there long enough to have an idea of where weaker points exist and since he shall be there longer he is interested in making suggestions. He is like the sophomore in college who has become disillusioned with the institution, sees the need for change and has enough at stake in the institution to seek change. The terminating patient is more like the senior who has accepted some of the weaknesses, and also whose interests have moved beyond the institution. The senior has less at stake and less to gain in any change in the institution. The intensive patients' responses within these two categories are spread out evenly touching on every subcategorical response except "accepting warm feeling" in the general category of "answers relating to

Figure 17 - Milieu Therapy

What Would Be More Helpful?





Key - Responses

Answers Relating To Patients And Self
- a. Taking Better Physical Care Of Self
- b. Being More Patient
- c. Being Happy
- d. Not Running
- e. Being Able To Accept Warm Feelings

Answers Relating To Patients And Staff
- a. More Close Relationships

Answers Relating To Staff
- a. A Unified Approach
- b. Larger Staff For Better Individual Care
- c. More Structuring
- d. Help Me To Talk
- e. Nurse's Giving Simple Medications Without Doctor's Orders
- f. More Attention

Answers Relating To Atmosphere And Activities
- a. More Spare Time Activities
- b. Freedom Not To Participate
- c. Consideration For Sleep And Rest
- d. Weekend Activities
- e. More Psychodrama
- f. More Family Therapy
- g. More Intensive Vocational Rehabilitation Counseling
- h. Special Requests: Patient Library On The Unit, A Truly Quiet Area, Getting Outdoors More, Discussion Topics For Patient Meetings, More Flexibility In Daily Schedules
- i. To Be Made To Feel More Like A Patient Than A College Student

Miscellaneous Responses
- a. Nothing
- b. No Comment
- c. No Answer

Key - Periods

Beginning ☐ N = 16
Intensive ☐ N = 36
Termination ☐ N = 10

patients and self". (Note the key on Figure 17 for the content of the specific subcategorical responses). The beginning period patient only mentioned in these two categories "to be happy", "helping me to talk" and "more attention". The terminating patients gave no responses relating to staff only.

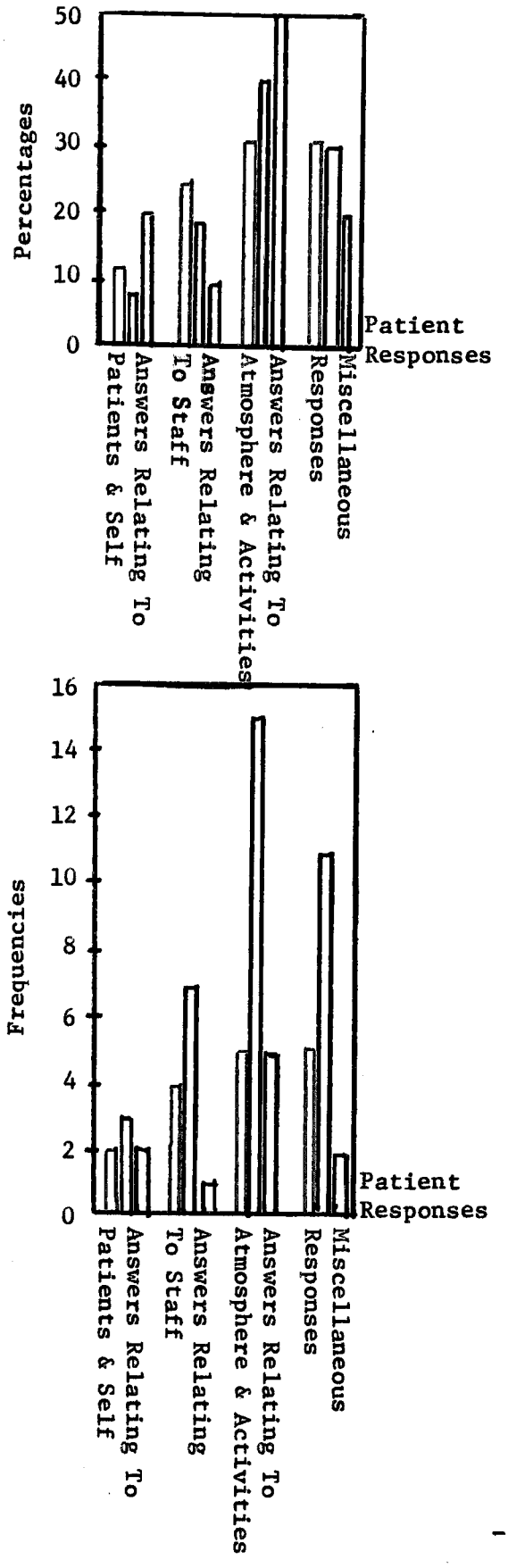
In "answers relating to atmosphere and activities" patients in all three periods gave the most responses to the need for "more spare time activities". Beginning and intensive period patients requested "weekend activities". The terminating patients were most likely not spending the weekends at the Institute and therefore were less concerned with this area. It is interesting that only a beginning period patient desired "the freedom not to participate". Participation in any situation in life is usually more difficult for the new person, who does not know the other members of the group.

Patients in all three periods made special requests which although not statistically significant may be beneficial ideas to those working on wards with the emotionally ill. The requests included: a library on the unit for patient use, a truly quiet area, getting outdoors more, topics for discussion at patient meetings and more flexibility in the daily schedule.

What Has Not Been Helpful?--In answer to this question Figure 18 shows that the highest peaks of responses for patients in all three periods were in "answers relating to activities and atmosphere". The second highest peaks for all three were in the broad "miscellaneous" category. Within the "atmosphere and activities" category

Figure 18 - Milieu Therapy

What Has Not Been Helpful?



Key - Responses

Answers Relating To Patients And Self
- a. Disruptive Patients
- b. Worrying
- c. Feeling Must Participate
- d. Not Seeing My Children

Answers Relating To Staff
- a. Staff Contradicting Doctor
- b. Argumentative Staff
- c. Obtrusive Staff
- d. Lack Of Close Relationships
- e. Staff Allowing Manipulative Behavior
- f. Service Of Psychiatric Aide

Answers Relating To Atmosphere And Activities
- a. Occupational Therapy And/Or Music Therapy
- b. Individual Complaints: Talking To So Many People In Evaluation, Noise, Unhelpful Experience With Vocational Rehabilitation, Inflexibility Of Daily Schedules
- c. Patient Meeting
- d. No Weekend Activities
- e. Too Much Spare Time
- f. Wednesday Night Activity Groups

Miscellaneous Responses
- a. Nothing
- b. No Comment
- c. No Answer

Key Periods

Beginning ☐ N = 16

Intensive ☐ N = 36

Termination ☐ N = 10

the intensive period patients mentioned every specific subcategory. The highest number of patients mentioning any particular subcategory was five and they said "patient meeting" was not helpful. This specific response was also mentioned by two beginning patients. No terminating patients mentioned this. Some of the terminating patients were not attending patient meetings because they were working on newly acquired jobs. "Too much spare time" was mentioned by all patients in the three periods of treatment.

In the "answers relating to staff only" patients in all three periods mentioned "argumentative staff" as not being helpful. Three patients in the intensive period complained of "obtrusive staff". Only patients within the beginning and intensive periods complained of the "lack of close relationships with the staff". Unit seems to be a more significant variable in this response. However the fact that no terminating patients mentioned this implies that perhaps these patients had formed close relationships with the staff or that in preparing to leave the Institute they were not as interested in having close relationships within the Institute. It is often not until the period of separation arrives that a person realizes how many attachments he actually has made.

In conclusion it is interesting that differences between the periods exist on the level of the broad categories more so than in the area of specific responses. The specific responses are so spread out that it is difficult to relate findings from which generalizations can be made. Perhaps the most interesting findings were the similarity of the patients' movement through

therapy with an individual's movement through human growth and development and the similarity between the positive, more critical, and less concerned more accepting attitude of patients as they move through their life at the Institute with that of a student or any other individual who enters, moves through and leaves an institution. The staff needs to be aware of the attitudes and needs of patients in each of these periods in order to be able to respond most therapeutically and realistically to the patients. This relates to the principle of meeting a patient where he is.

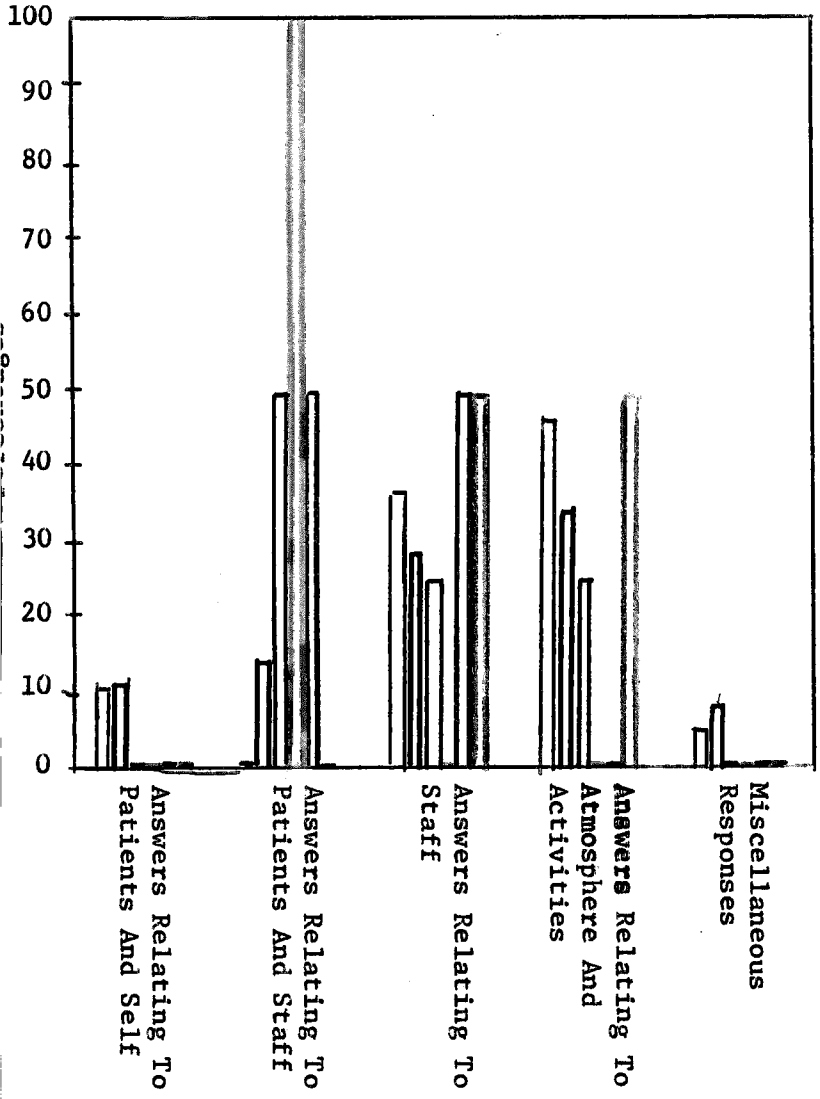
DIAGNOSIS

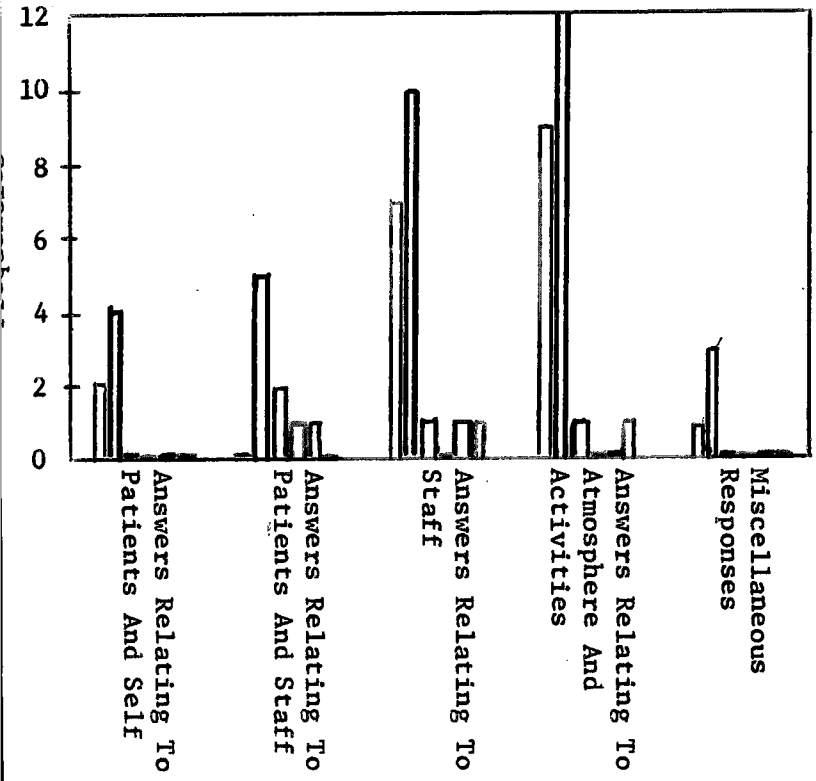
The diagnostic variable held little significance in relation to the patients' attitude toward the milieu in which they operated. Due to the sample sizes (depressed, thirty-four; schizophrenic, nineteen; adolescent adjustment reaction, four; anxiety reaction, two; phobic, two; sociopath, one) a comparison will only be made between the schizophrenic patients' responses and those of the depressed patients. Even a comparison between these two diagnoses has limitations because of the discrepency between a sample of thirty-four and one of nineteen.

What Has Been Most Helpful?--When one looks at Figure 19, one can see that the highest peaks for schizophrenics and depressed patients are in the category of "answers relating to atmosphere and activities". The second highest peak for both lies in "answers relating to staff only". The one difference is seen in that only depressed patients gave responses which fell into the area of "answers relating to

Figure 19 - Milieu Therapy

What Has Been Most Helpful?





Key - Responses

Answers Relating To Patients And Self
- a. Being With Other Patients
- b. To Know Myself

Answers Relating To Patients And Staff
- a. Friendly Attitude
- b. Forming Close Relationships

Answers Relating To Staff
- a. General Attitude And Availability
- b. Supportive Attitude
- c. Effieiency
- d. Talking With The Psychiatric Aide

Answers Relating To Atmosphere And Activities
- a. A Refuge From Outside Pressures
- b. Singular Responses: Patient Meetings, Psychological Testing, Thorough Medical Attention, Non-Hospital Atmosphere
- c. Vocational Rehabilitation
- d. Occupational Therapy, Music Therapy, And/Or Recreational Therapy
- e. Sleep And Rest
- f. Psychodrama

Miscellaneous Responses
- a. No Comment
- b. No Answer

Key - Diagnoses

Schizophrenia	N = 19
Depression	N = 34
Adolescent Adjustment Reaction	N = 4
Sociopath	N = 1
Phobic	N = 2
Anxiety Reaction	N = 2

patients and staff".

It is necessary for the reader to understand that the broad categorical areas shown on the graphs representing responses to the milieu therapy were devised by the researchers. The actual and specific patient responses are given in the key and fall within the main categories. Thus although there may be little difference between the diagnoses in the general categories, certain differences do exist in relation to the specific responses. In relation to "what has been most helpful" and falling under the heading of "answers relating to atmosphere and activities", three schizophrenics and three depressed patients found one of the three special therapies (occupational therapy, music therapy, and recreational therapy) most helpful. Two patients within each of the two diagnoses saw the hospital as a "refuge from outside pressures and problems" and thought this was the most helpful aspect of the milieu. Three depressed patients gave "singular responses" whereas only one schizophrenic gave this response. The depressed "singular responses" involved: (1) thorough medical attention, (2) non-hospital (college-like) atmosphere, and (3) psychological testing. The schizophrenic patient found patient meeting most helpful. It is interesting to note that this was the only positive response given regarding patient meeting. Secondly, it is relevant that as will be seen later no schizophrenic reacted negatively to patient meeting in our study. Depressed patients did react negatively to this meeting. As for the other specific responses relating to "activities and atmosphere" they were appreciated equally by both depressed and schizophrenic

patients.

Within "answers relating to staff" four schizophrenic and four depressed patients felt that the "general attitude and availability of staff" was most helpful and two schizophrenics and four depressed patients felt the "supportive attitude" was most helpful. It is interesting to note that three depressed patients found the "friendly attitude" of patients and staff most helpful and two found that "forming close relationships" with patients and staff most helpful. No schizophrenics gave either of these responses. This might be expected insofar as most schizophrenics have difficulty forming and interacting within close relationships. Yet the schizophrenic patient does respond to support from others and this is seen by their responses of finding "being with other patients" and the "supportive attitude" of the staff helpful. It is only the "friendly attitude" and "close relationships" which are noticeably lacking in the schizophrenics responses. The schizophrenic's tendency to withdraw and his tendency to be confused or nonfunctional in an unstructured situation such as the intricacies of a close relationship may be partial explanations for the absence of schizophrenic responses in these areas. Often because of a schizophrenic's withdrawal tendencies, staff members are not as friendly with them. The staff member does not usually reject the patient but rather the friendliness of the staff member is not drawn out by the schizophrenic who is so often quiet and not as openly demanding of attention and friendship. These findings point to the need of the schizophrenic for other people even though

the relationship may not be seen by the schizophrenic in terms of a friendship base.

What Would Be More Helpful?--In response to this question, Figure 20 reveals that the schizophrenic's highest frequency of responses falls in the category of "answers relating to atmosphere and activities" while the highest frequency of depressed patients' responses falls in the "miscellaneous category". The second highest frequency for depressed patients falls in the category "answers relating to atmosphere and activities". The second highest for the schizophrenics falls in both the "miscellaneous" category and "answers relating to patients and staff".

The fact that so many depressed patients answered in the miscellaneous category is puzzling. It is even more puzzling when you see that ten of the thirteen depressed patients within this category gave no answer at all while only one schizophrenic patient gave no answer. This is a significant difference between the depressed patients and the schizophrenic patients. Several questions should be raised: (1) was the question more threatening to depressed patients than schizophrenic patients? or (2) did the depressed patients have fewer ideas for improvements in the sense that they were basically more satisfied with the milieu as it stood than schizophrenic patients? If they were fully satisfied, it would seem that more would have given the specific response of "nothing" rather than no answer at all. Giving no answer is a way of avoiding the issue and not committing one's self. Approximately 60 per cent

Figure 20 - Milieu Therapy

Diagnosis Variable - What Would Be More Helpful?

Patient Responses	Schiz.		Dep.		A.A.R.		Sociopath		Phobic		Anx.-Reac.	
	f	%	f	%	f	%	f	%	f	%	f	%
Answers Relating To Patients And Self	3	15.8	3	8.8	0	0	0	0	0	0	0	0
Answers Relating To Patients And Staff	0	0	0	0	0	0	1	100	0	0	0	0
Answers Relating To Staff	2	10.5	6	17.6	1	25	0	0	0	0	0	0
Answers Relating To Atmosphere And Activities	11	57.9	12	35.3	1	25	0	0	1	50	2	100
Miscellaneous Responses	3	15.8	13	38.2	2	50	0	0	1	50	0	0
	N = 19		N = 34		N = 4		N = 1		N = 2		N = 2	

Key - Diagnosis

Answers Relating To Patients And Self
- a. Taking Better Physical Care Of Self
- b. Being More Patient
- c. Being Happy
- d. Not Running
- e. Being Able To Accept Warm Feelings

Answers Relating To Patients And Staff
- a. More Close Relationships

Answers Relating To Staff
- a. A Unified Approach
- b. Larger Staff For Better Individual Care
- c. More Structuring
- d. Help Me To Talk
- e. Nurse's Giving Simple Medication Without Doctor's Order

Answers Relating To Atmosphere And Activities
- a. More Spare Time Activities
- b. Freedom Not To Participate
- c. Consideration For Sleep & Rest
- d. Weekend Activities
- e. More Psychodrama
- f. More Family Therapy
- g. More Intensive Vocational Rehabilitation Counseling
- h. To Be Made To Feel More Like A Patient Than A College Student
- i. Special Requests: Patien Library, A Truly Quiet Area, Getting Outdoors More, Discussion Topics For Patient Meetings, More Flexibility In Daily Schedule

Miscellaneous Responses
- a. Nothing
- b. No Comment
- c. No Answer

Key - Diagnosis

Schiz. = Schizophrenia

Dep. = Depressed

A.A.R. = Adolescent Adjustment Reaction

Anx. Reac. = Anxiety Reaction

of the depressed patients' responses fell outside of the miscellaneous category while approximately 84 per cent of the schizophrenic patients fell outside of this category. This means that 84 per cent of the schizophrenic patients gave specific suggestions. Could it be that the depressed patient does recognize positive aspects of a situation as indicated by his responses to the first question but does not have as great a tendency to recognize the possibility for improvement and consequently feels that it is useless to make suggestions. This is purely a speculative answer and may not have any application. Also the researchers have been told that many of the patients admitted with a diagnosis of depression had neurotic rather than psychotic depressions. If this is true, then possibly because the neurotic is in closer touch with reality, he felt the threat in the question more than the psychotic patient. In relation to this discussion it is interesting to note that every patient given the specific diagnosis of manic-depressive, a psychotic condition, gave only specific responses and none fell in the "no answer" category. All of these suggested explanations of the difference in no answer responses are given as speculations only. A more intense analysis would be required before any conclusions could be drawn.

In relation to needed improvements in activities and atmosphere of the milieu two schizophrenics and four depressed patients desired "more spare time activities". Patients of both diagnoses requested "weekend activities". Many patients get restless and bored on the unit. Some, used to leading busy lives, find it difficult to adjust to a slower pace. During the week the activities of occupational

therapy, music therapy and recreational therapy are available. There are cards, games, records and ping pong available on the unit. Most patients can leave the unit and take walks on the grounds. At night there are movies and often other activities. Some patients do not take advantage of what is available. Even though some do, they still get restless as these activities do not fill up that much of a week. There is an absence of activities on the weekends. Most patients leave on the weekends which causes those left behind to become lonely and bored. There does seem to be a need for some planned activities on the weekends.

In contrast to this, one schizophrenic patient wished the freedom not to participate in activities. The schizophrenic patient may find certain activities which require interaction with others both painful and difficult. However it is often through these activities that the patient may achieve a certain level of functioning with others. This usually happens when other members of the group offer him support and therefore build his self-esteem.

Another response that was given only by schizophrenics, and two of them, was a request for a "more intensive vocational rehabilitation program". An intensive vocational rehabilitation program does exist at the Georgia Mental Health Institute. However some schizophrenics are difficult to place in jobs because they require a very structured job, a job which does not require them to interact with others to a great extent and in some cases one which does not require abstract thinking. This may play a part in the fact that two schizophrenics were disappointed with the

vocational rehabilitation program. On the other hand this response requires looking at the patients' side of the picture. Could it be that the counselor did not have or did not take the time and patience to help the patient set more realistic goals? This requires great skill as the counselor often needs to build the patient's self-confidence and at the same time help him to lower his immediate goals for a job. Could the counselor have felt discouraged himself and therefore avoided the patient or the issue? Many personality factors may have entered into the picture. However it is necessary to recognize that of all the diagnoses only schizophrenics found vocational rehabilitation dissatisfying. Since one schizophrenic found vocational rehabilitation the most helpful aspect of the milieu, it cannot be generalized that vocational rehabilitation is running into difficulties with all schizophrenics.

In "answers relating to staff", only two schizophrenics gave specific responses and they fell into the areas of "more structuring" and "more attention". Certainly the "more structuring" response can be understood as appropriate to the schizophrenic's needs. "More attention" was also requested by depressed patients. One interesting contradiction in depressed patients' responses involved two patients desiring that the staff would help them to talk and one depressed patient who wished the staff would not talk to the patient. These two responses were given only by depressed patients and reveal the ambivalence that these patients feel in discussing their problems. The first two patients are saying they find it difficult to talk but do not wish to be left alone. The third patient is saying he

finds it difficult to talk and does wish to be left alone. In the first response there is a plea for help and in the second there is a hostile response to the help offered.

One last singular response which is worth mentioning as it stands in contrast with most of the responses is "being treated more like a patient". This was given by a schizophrenic patient and may correspond to the desire for "more structuring" and "more attention". The way the patient stated this response was "I would rather be made to feel more like a patient than a student in a college dormitory". The connotation of the word "patient" usually indicates a more regulated, structured role in which others take care of you. A college student, on the other hand, is expected to do more for himself and to provide much of his own structure. This patient wished to be taken seriously as a patient and perhaps wished to give in to his illness. On the other hand this particular patient may need more support from the staff than he is getting to fight his illness.

What Has Not Been Helpful?--Figure 21 reveals that in answer to this question, schizophrenics had a higher percentage, 37 per cent, of patient responses falling in the "miscellaneous" category than the depressed patients, 27 per cent. However, once again the majority of the depressed specific responses in this main category fell into the no answer subcategory while the majority of schizophrenic responses fell into the "nothing" (i.e.everything is in some way helpful) subcategory.

Figure 21 - Milieu Therapy

Diagnosis Variable - What Has Not Been Helpful?

Patient Responses	Schiz.		Dep.		A.A.R.		Sociopath		Phobic		Anx. Reac.	
	f	%	f	%	f	%	f	%	f	%	f	%
Answers Relating To Patients And Self	2	10.5	5	14.7	0	0	0	0	0	0	0	0
Answers Relating To Staff	4	21.1	5	14.7	2	50	1	100	0	0	0	0
Answers Relating To Atmosphere & Activities	6	31.6	15	44.1	2	50	0	0	0	0	2	100
Miscellaneous Responses	7	36.8	9	26.5	0	0	0	0	2	100	0	0
	N = 19		N = 34		N = 4		N = 1		N = 2		N = 2	

Key - Responses

Answers Relating To Patients And Self
- a. Disruptive Patients
- b. Worrying
- c. Feeling Must Participate
- d. Not Seeing My Children

Answers Relating To Staff
- a. Staff Contraditing Doctor
- b. Argumentative Staff
- c. Obtrusive Staff
- d. Lack Of Close Relationships
- e. Staff Allowing My Manipulative Behavior
- f. Service Of Psychiatric Aide

Answers Relating To Atmosphere And Activities
- a. Occupational Therapy And /Or Music Therapy
- b. Patient Meetings
- c. Individual Complaints: Talking To So Many People In Evaluation, Noise, Unhelpful Experience With Vocational Rehabilitation, Inflexibility Of Daily Schedule
- d. No Weekend Activities
- e. Too Much Spare Time
- f. Wednesday Night Activity Groups

Miscellaneous Responses
- a. Nothing
- b. No Comment
- c. No Answer

Key - Diagnoses

Schiz. = Schizophrenia

Dep. = Depressed

A.A.R. = Adolescent Adjustment Reaction

Anx. Reac. = Anxiety Reaction

The highest frequency of depressed patients' responses fell into the category of "answers relating to activities and atmosphere". Of these six specifically said "patient meetings" had not been helpful. No schizophrenics said this. From personal observation of patient meetings on Unit A, it was noticed that many depressed patients did participate verbally in patient meetings while very few if any schizophrenics verbally participated. Thus the schizophrenic did not enter directly into any conflictual situation that arose in the meeting as the depressed patients did. Patient meetings are so unstructured that one would expect the schizophrenic to react negatively. Instead the only schizophrenic reaction offered in relation to patient meetings was positive. Thus the participation factor would seem to be significant for at least one schizophrenic. Although he did not participate himself, evidently he did identify with some who did express themselves and did benefit from the way this individual's feelings were handled. The depressed patients however only expressed negative feelings towards these meetings. This will be dealt with more extensively in the final chapter.

Both schizophrenic and depressed patients (three schizophrenics and two depressed) said occupational therapy and/or music therapy had not been helpful. Three depressed patients and no schizophrenics were of the opinion that the "Wednesday night activities" had not been helpful. These Wednesday night activities only existed in Cottage II and were discussed further in relation to the unit variable. The schizophrenics may have appreciated the structuring

these activities provided whereas the depressed patients may have preferred another type of activity. However, some depressed patients desired "more spare time activities". The unit variable may make more significance in this area as in Cottage II at least three-fourths of the patients at this time had an admitting diagnosis of depression.

In "answers relating to staff", three depressed patients said that the "lack of close relationships" had not been helpful. No schizophrenics gave this response. This corresponds to the depressed patients' appreciation of "close relationships" and "friendly attitude" as expressed in their response to "what has been most helpful". The schizophrenic patient does not seem as concerned with friendship as he does with supportive based relationships. It is necessary to note here that the problem of "lack of close relationships" appeared only in Cottage II where most of the patients were depressed. Thus the question has to be raised as to whether diagnosis or unit is the significant variable in this response. If depressed diagnosis is the significant variable, then an obvious need of depressed patients has revealed itself in this study both in their responses to individual therapy as well as milieu therapy. As it stands this need for close relationships is not being adequately filled in Cottage II. However, if diagnosis alone is the significant variable, then it is puzzling that none of the depressed patients in the other two units mentioned "lack of close relationships". It is most probable that the two variables of diagnosis and unit are interacting and that neither alone

can account for the situation in Cottage II which had by far the highest depressed patient population.

In "answers relating to patients and self" both depressed and schizophrenic patients mentioned that "disruptive patients had not been helpful". Patients get annoyed and are often threatened by the behavior of other patients.

Thus when the data is carefully examined certain differences as well as similarities are recognized between schizophrenics and depressed patients. Unfortunately the present study does not show how statistically significant these differences and similarities are. From the data of the present study, the researchers can only infer that in some areas there are differences in the concerns or feelings of schizophrenic and depressed patients. This was illustrated by the differences concerning close relationships, attitudes toward patient meetings, and the noncommitted state of not answering. It might be said that both groups desire more activities and yet the depressed patient is less concerned with the structuring quality and is less fearful of interaction with others than the schizophrenic patient.

SUMMARY OF THE RESPONSES OF PATIENTS WITH ADOLESCENT ADJUSTMENT REACTION, PHOBIC REACTION, ANXIETY REACTION, AND SOCIOPATHIC PERSONALITY CONCERNING MILIEU THERAPY

The other four diagnostic categories will only be mentioned briefly since the samples were too small to allow conclusive findings. As Figure 19 reveals, the four adolescent patients mentioned four

areas as being most helpful: (1) friendly attitude (2) close relationships with patients and staff (3) supportive attitude of staff and (4) the three special therapies: occupational therapy, music therapy and recreational therapy. As can be seen on Figure 20 their suggestions for improvement included "more family therapy" and a "larger staff so that a patient would not feel guilty about needing extra attention by the staff". As for "what had not been helpful" Figure 21 indicates that the adolescents mentioned: (1) argumentative staff, (2) obtrusive staff, (3) patient meetings and (4) too much spare time. The authority conflict of adolescents reveals itself in these last responses. Also the ambivalence regarding dependence and independence in their desiring a larger staff and yet rebelling against some of the staff. The adolescents on the whole seem to participate in the available activities and to enjoy them. It is interesting that an adolescent mentioned family therapy since in the case of most adolescent adjustment reactions the adolescent's problem is a symptom of a family's problem.

The sociopath found most helpful the close relationships he had with patients and staff. He said more of these close relationships would be more helpful to him. Finally he said that the staff's allowing his manipulative behavior had not been helpful. It is significant that a sociopath lays so much emphasis on relationships because his hostile or manipulative behavior tends to drive people away. His behavior, though a protection from rejection, tends to prevent the thing he wants most. It is important that staff realize

this so that the basic need can be met. This patient is also asking for the staff to control his behavior as he is not yet able to control it himself.

The two phobic patients found most helpful the "friendly attitude of patients and staff" and the "efficiency of staff". One of them said "more psychodrama" would more helpful. This was also mentioned by both a schizophrenic and depressed patient. The other phobic said "nothing" would be more helpful. One did not answer what had not been helpful and the other said "nothing".

Of the two patients diagnosed with anxiety reaction one found the "general attitude and availability" of staff most helpful and the other found the three special therapies most helpful. Both felt "more spare time activities" would be more helpful. Often patients experiencing an anxiety reaction have the need to stay busy. As for what had not been helpful one mentioned "too much spare time" and the other the "Wednesday night activities". They had the need to be busy and yet the responsibility of planning activities in their group and the need to interact closely with other patients may have aroused anxiety. Also what may have been a need of one patient may not have been the need of the other. It would depend upon the underlying problem producing the anxiety reaction.

SEX

The sex variable was not expected to make a significant difference in the ways patients responded to the milieu therapy. In observing the data the sex of the patient does not seem significant, for in

the general categories of responses for each question, both sexes tend to have similar percentages of responses. In response to "what has been most helpful", Figure 22 shows that the general categories for both sexes are in descending order: "answers relating to atmosphere and activities", "answers relating to staff", "answers relating to patients and staff", "answers relating to patients and self" and "miscellaneous responses". It is interesting to note that no responses of male patients to this question are found in the "miscellaneous" category while the responses of females fall into this category -- "no answer" (3), "no comment" (1). In response to "what would be more helpful?", there were only three males that did not answer while there were nine females who did not answer and one who said "no comment". In responses to the final question, "what has not been helpful", four males did not answer while six females did not answer and one gave the "no comment" response.

Thus it can be seen that males tend to respond more than females. It might be speculated that the male in his role as businessman, husband and father is called upon to assess situations and is expected to be more candid in expressing his observations. The woman also has the ability to assess situations but is not as frequently called upon to report what she sees in clear specific terms. Because of the number of no answer responses among female patients, the female does not seem as bold as the male. Her lack of response may indicate that she has an underlying criticism or suggestion which she is either afraid or unwilling to share. It would be interesting to do further

Figure 22 - Milieu Therapy

Sex Variable - What Has Been Most Helpful?

Patient Responses	Males		Females	
	f	%	f	%
Answers Relating To Patients And Self	1	6.3	5	10.9
Answers Relating To Patients and Staff	3	18.6	6	13
Answers Relating To Staff Only	6	37.5	14	30.4
Answers Relating To Atmosphere & Activities	6	37.5	17	37
Miscellaneous	0	0	4	8.7
	N = 16		N = 46	

Key-Responses

Answers Relating To Patients And Self
- a. Being With Other Patients
- b. To Know Myself

Answers Relating To Patients And Staff
- a. Friendly Attitude
- b. Forming Close Relationships

Answers Relating To Staff Only
- a. General Attitude And Availability
- b. Supportive Attitude
- c. Efficiency
- d. Talking With Psychiatric Aide

Answers Relating To Atmosphere And Activities
- a. Having A Refuge From Outside Pressure
- b. Singular Responses: Patient Meeting, Thorough Medical Attention, Non-Hospital Atmosphere, Psychological Testing
- c. Vocational Rehabilitation
- d. Occupational Therapy, Music Therapy And Recreational Therapy
- e. Sleep And Rest
- f. Psychodrama

Miscellaneous Responses
- a. No Comment
- b. No Answer

research in the area of the way males and females respond in an attempt to ascertain whether or not there are types of questions which tend to draw responses from one sex rather than the other.

What Has Been Most Helpful To You?--In relation to this question patients of both sexes mentioned the Institute's acting as a "refuge" and the three special therapies: "occupational therapy, recreational therapy and music therapy". The Institute does act as a refuge in that many patients are removed from the specific environmental pressures that they were surrounded by before entering the Institute. However it is hoped that through the activities and life at the Institute that the patient does not retreat, but continues to interact with other people in situations similar to those of the outside world but perhaps a little less threatening. Many patients recreate the outside experience or patterns of relationships within the Institute. However the Institute has enough of a trained staff and affords just enough protection hopefully to allow the patient to gain insight in the way he relates to others and to work through these patterns of relating so that he can learn ways of relating which more healthily meet his needs as well as those to whom he is relating.

The three special therapies were recognized as being most helpful by three male patients and five female patients. These three therapies particularly foster the building of self-esteem and self-confidence and provide appropriate ways for patients to express their feelings. They also provide group experiences

in which patients can test and learn satisfying and healthier ways to relate to other people. The activities they provide are a means to these ends.

Three female patients mentioned vocational rehabilitation as being most helpful. No males gave this response. It would be expected that the reverse would be true as vocational rehabilitation has assisted many males in finally getting good and appropriate jobs. However more and more females are working. Some of the single females have had little training for jobs. Vocational rehabilitation offers training or pays for patients to receive the kinds of training they need. Some of the women have been bored or frustrated housewives. Many of these women would be better off working and paying someone to care for the children. The prospect of a job in which they might achieve is a happy prospect for a woman who feels like a failure in the domestic area of life. It was also only females who suggested a "more intensive vocational rehabilitation program".

Female patients also were the only sex to mention "psychodrama" and "sleep and rest" as being most helpful. However one male did mention in response to "what would be more helpful?" that he would like "more psychodrama". In relation to psychodrama the unit variable seems to be more significant. However, in response to "what would be more helpful?" females again were the only ones to mention "more consideration for sleep and rest". A comical speculation could be that women are the lazier sex and that males are the more compulsive sex.

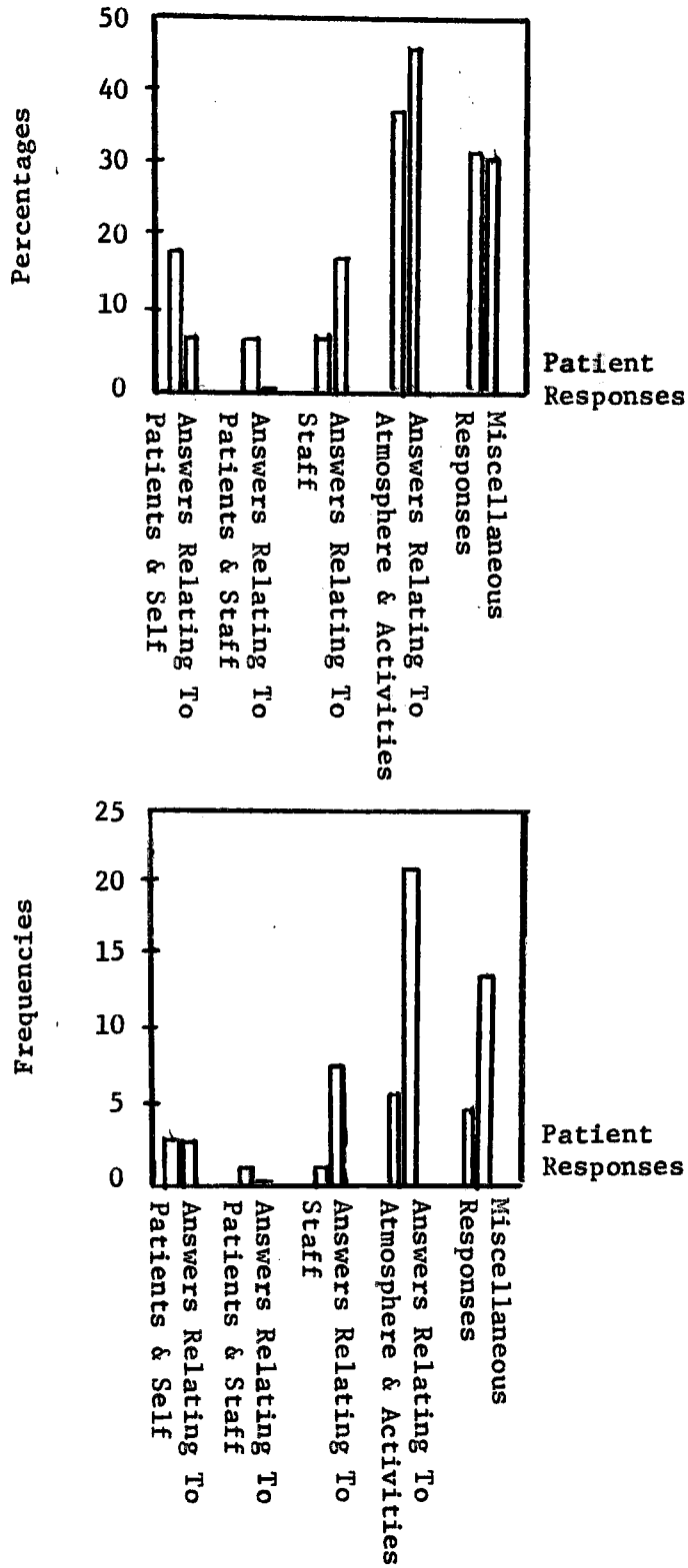
Both male and female patients mentioned all the

subcategorical responses in the main categories of "answers relating to patients and self", "answers relating to patients and staff", and "answers relating to staff only". The highest frequencies found in the subcategorical responses of these main categories are in "being with other patients", "friendly attitude of patients and staff", "forming close relationships with patients and staff", "general attitude and availability of staff" and "supportive attitude of staff". Once again relationship is more important than efficiency. This corresponds to the responses to individual therapy in which the patient finds the person-to-person quality of the relationship more helpful than the professional excellence of the therapist.

What Would Be More Helpful To You?--Figure 23 reveals that the main categories with the highest frequencies for both sexes are, in descending order: "answers relating to atmosphere and activities", "miscellaneous responses", "answers relating to patients and self", "answers relating to staff only" and "answers relating to patients and staff". The only exception to this order is that "answers relating to staff only" precedes "answers relating to patients and self" among female patients. Female patients offered many suggestions for improvement among the staff whereas only one male patient answered in this category. He desired "more attention". Female responses fell in all seven areas: "the need for unified approach", "the need for a larger staff", "more structuring", "helping me to talk", "nurse's giving simple medications", "staff not forcing me to talk", and "more attention". Thus although, as mentioned before,

Figure 23 - Milieu Therapy

What Would Be More Helpful?



Key - Responses

Answers Relating To Patients & Self
- a. Taking Better Physical Care Of Self
- b. Being More Patient
- c. Being Happy
- d. Not Running
- e. Being Able To Accept Warm Feelings

Answers Relating To Patients & Staff
- a. More Close Relationships

Answers Relating To Staff Only
- a. A Unified Approach
- b. Larger Staff For Better Individual Care
- c. More Structuring
- d. Help Me To Talk
- e. Nurse's Giving Simple Medications Without Doctor's Order
- f. More Attention

Answers Relating To Atmosphere And Activities
- a. More Spare Time Activities
- b. Freedom Not To Participate
- c. Consideration For Sleep And Rest
- d. Weekend Activities
- e. More Psychodrama
- f. More Family Therapy
- g. More Intensive Vocational Rehabilitation Counseling
- h. To Be Made To Feel More Like A Patient Than A College Student
- i. Special Requests: Patient Library On The Unit, A Truly Quiet Area, Getting Outdoors More, Discussion Topics For Patient Meetings, More Flexibility In Daily Schedules

Miscellaneous Responses
- a. Nothing
- b. No Comment
- c. No Answer

Key - Sexes

Male N = 16
Female N = 46

more females gave no answer than males, females were not fearful of offering suggestions in this area. An interesting sociological question that could be asked in regards to this data is how much is the changing role of women effecting the female patient and staff members who are treating female patients? Some women are ambivalent about their role. Some prefer the traditional role and some prefer the newer woman's role which involves the independence and ambition and interest in a career that are traditionally the man's role only. Which women patients fit in which category? What are the staff members reaction to the change? Could this have anything to do with why only females mentioned "a unified approach" as being more helpful and "staff-doctor contradiction" as not helpful? Could there be hidden staff disagreement in the area of how to treat a woman and what the goals of treatment are?

The "answers relating to patients and self" in "what would be more helpful" were concerned totally with self. They were more personal or introspective responses. Three male patients mentioned "taking better physical care of self", "being more patient", and "being happier". Three female patients mentioned "being happier", "not running", and "being able to accept warm feelings from others". In response to the other two questions "what has been most helpful?" and "what has not been helpful?", the majority of responses in this main category related to other patients rather than self. When a suggestion was required rather than a value judgment, the patients used the insight they had gained regarding themselves or mentioned their own personal goals. The patients were all in the same boat--all dealing with personal problems.

When it came to how patients could improve, the patient looked at himself only. However critical suggestions could be made regarding staff and the activities which make up the treatment program. The purpose for both staff and the activities at the Institute is functional. The purpose for a patient's being at the Institute is personal. To attack the staff is to attack its function. To attack a patient is to attack the person. The former is safer, easier and not as presumptuous as the latter.

In the area of "atmosphere and activities", members of both sexes suggested "more spare time activities", "weekend activities", "more psychodrama" and "special requests" such as a library on the unit and a truly quiet area.

What Has Not Been Helpful?--Figure 24 shows that in response to this question the main categories for both sexes are in descending order of frequency: "answers relating to atmosphere and activities", "miscellaneous responses", "answers relating to staff" and finally "answers relating to patients and self". In the category of "answers relating to atmosphere and activities" five female patients were the only ones to say that "occupational therapy and music therapy" were not helpful. This was the only subcategory in this area which no males mentioned. It is uncertain why this is because five females also found music therapy and occupational therapy the most helpful. It could be that these patients had difficulty relating to the other people in their group, felt they lacked the talent or skill for either of these areas, were not able to be free enough to express

Figure 24 - Milieu Therapy

Sex Variable - What Has Not Been Helpful?

Patient Responses	Males		Females	
	f	%	f	%
Answers Relating To Patients And Self	1.	6.3	6	13
Answers Relating To Staff Only	3	18.6	9	19.6
Answers Relating To Atmosphere & Activities	6	37.5	19	41.3
Miscellaneous Responses	6	37.5	12	26.1
	N = 16		N = 46	

Key - Responses

Answers Relating To Patients & Self
- a. Disruptive Patients
- b. Worrying
- c. Feeling Must Participate
- d. Not Seeing My Children

Answers Relating To Staff Only
- a. Staff Contradicting Doctor
- b. Argumentative Staff
- c. Obtrusive Staff
- d. Lack Of Close Relationships
- e. Staff Allowing My Manipulative Behavior
- f. Service Of Psychiatric Aide

Answers Relating To Atmosphere & Activities
- a. Occupational Therapy And Music Therapy
- b. Individual Complaints: Talking To So Many People In Evaluation, Noise, Experience With Vocational Rehabilitation Not Helpful, Inflexibility Of Schedules
- c. Patient Meetings
- d. No Weekend Activities
- e. Too Much Spare Time
- f. Wednesday Night Activities

Miscellaneous Responses
- a. Nothing
- b. No Comment
- c. No Answer

their feelings through the media or perhaps the individuals, not being able to achieve in these areas, felt like failures rather than more self-confident.

The specific response relating to "atmosphere and activities" which was mentioned most frequently as not being helpful was "patient meeting". Two males and five females mentioned it. One male and three females said the "Wednesday night activity groups" in Cottage II were not helpful. Since there were so few males on the unit these Wednesday night activity groups were divided according to sex with the males all in one group. Sex therefore could have been a factor in relation to these groups but does not appear to be.

In the category of "answers relating to staff", male and female patients both mentioned "argumentative staff as not being helpful". "Lack of close relationships" is mentioned by three female patients and no male patients. This particular response has been narrowed down to three female depressed patients in Cottage II. How much sex is interlocking with the other variables is not certain. It would seem that sex is the least significant, for if it were the most significant it would seem that female patients in the other units or with other diagnoses would have mentioned it. The concern for close relationships does not seem to be strictly female as males as well as females said that "forming close relationships" was most helpful and only a male suggested that "more close relationships" would be more helpful.

In "answers relating to patients and self" there were two personal responses. A male said "worrying" and a female said "not

seeing my children" (who were in foster placement). Four female patients said "disruptive patients" were not helpful. No male patients complained of this. No males in either response to the following questions "what would be more helpful?" or "what has not been helpful?" mentioned any weakness among the patients. The male tended to be more introspective. The females were critical of peer group members as not being helpful. Since there were more females than males, the females may have had closer group interaction and therefore known each others' weaknesses as well as strengths better. It would be interesting to know also whether there was a competitive element among the large number of female patients for both the male patients' attention and the staff's attention. If this were true, the females might tend to be more critical of their peers.

Little conclusive evidence can be drawn from the data concerning the relevance of the sex variables. Overall no striking differences exist between members of the different sexes in relation to the milieu therapy. Since the units are mixed sex was not expected to act as a significant variable in the area of milieu therapy. However, certain minor differences are implied (not proved) by the data. First more males tend to answer the questions than females. Secondly, when asked for a suggestion or negative value judgment males tend to give introspective or personal responses or answers that relate to the more impersonal entities of activities and atmosphere. Females when asked for a suggestion or negative value judgment tend to be less introspective and more openly critical of staff as well as atmosphere and activities. Female patients are even critical of other patients

whereas no male patients are. Female patients only mentioned the "staff-doctor contradiction" or need for a "unified approach". The sexes were similar in their valuing "being with other patients", "their relationship with staff members and patients", and "the three specialized therapies of occupational therapy, music therapy and recreational therapy". They were similar in their suggestions for "more attention", "more spare time activities", "more weekend activities" and "more psychodrama". Both sexes alike complained of "argumentative staff", "patient meetings", "too much spare time", "no weekend activities" and "Wednesday night activity groups. Sex does not seem to effect consensus in these areas.

CHAPTER IV

ANALYSIS OF THE DATA: SOCIAL WORK SERVICE

QUESTIONS ASKED

In your relationship with your social worker:

1. What has been most helpful to you?
2. What would be more helpful to you?
3. What has not been helpful?

UNIT

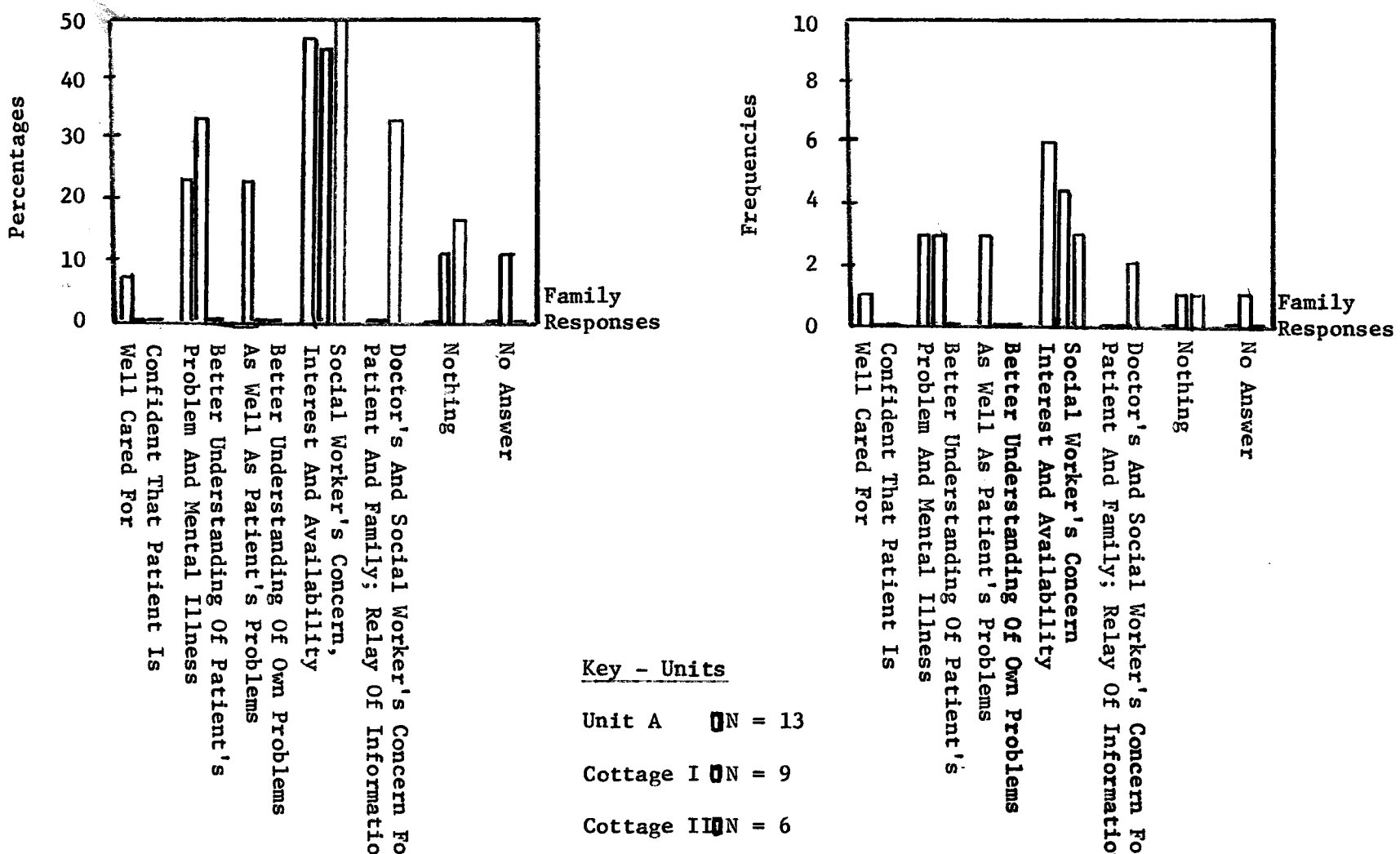
The sample sizes of the three units studied are not equal. The number of families responding to the questionnaire were: in Unit A, thirteen, in Cottage I, nine and in Cottage II, six. This represents 51 per cent of the total questionnaires mailed. Although the findings might not be statistically significant, the information received from the respondents may be of some assistance in evaluating the services being offered by the Social Work Department at the Institute. The data collected indicates that there is a greater similarity than difference between the three units in the areas of what the patient's family perceives as being most helpful and what has not been helpful. The responses in the three units differ in the area of offering specific suggestions for improvement in the service.

What Has Been Most Helpful In Your Relationship With Your Social Worker?

--In response to this question Figure 25 illustrates that all three unit's peak responses from the families were in the area "social worker's (family counselor's) interest, concern and availability". The percentage of responses in this area from all units, 46 per cent in Unit A, 44 per cent

Figure 25 - Social Work Service

What Has Been Most Helpful?



in Cottage I, and 50 per cent in Cottage II, indicates that the families felt that the social worker is not only interested in them as individuals and members of a family unit, but also concerned with the effect of the patient's hospitalization on their feelings and their lives. Hospitalization of a family member, particularly in a mental institution, can be a very traumatic experience. The social worker's availability to the family members to allay their fears and anxieties and to assist them in maintaining family balance is an important part of the total treatment plan for the patient.

The second highest response to the question, "what has been most helpful?" from the families on Unit A and in Cottage I was in the area of "better understanding of patient's problem and mental illness". Although there has been some change in this regard in recent years, mental illness is still not completely understood or accepted by the general public. Old taboos that the mentally ill are to be shunned or hidden away are still pervasive throughout American society. Twenty-three per cent of Unit A and 35 per cent of Cottage I families indicated that the social worker, through contact with family members, helped or fostered their understanding of mental illness.

Twenty-three per cent of Unit A families also said that their "better understanding of their own problems as well as patient's" was most helpful. This response was not given by families in Cottages I and II. Frequently the family members of mentally ill patients perceive the patient's problem as being his alone and wish to deal only with this. The response given by these family members indicates that the social worker has helped them to become aware of their own problems and how

they may be contributing factors to the patient's illness.

In Cottage II, the second highest peak response was "interest and concern of doctor; relay of information". This response was given by families in Cottage II and indicates the importance family members place on receiving information regarding the hospitalized family member. This will be seen more clearly in response to the question "what has not been helpful?"

"Confidence that patient is well cared for" was a response given by one family member in Unit A only as being the most helpful.

Both CottagesI and II had one family each who answered "nothing" had been most helpful. The reason for this is unknown but implies the need for further questioning. For example: were these responses given by families, whose patient member being recently admitted, had not become intensely involved with the social worker? According to the period variable, these responses were in the intensive period; hence, the patient had been hospitalized for at least four weeks. Another question which might be asked is: were the family members overly dependent and demanding more of the social worker's time than could be realistically given? Still another question might be: had these families become aware of their own involvement in the patient's problem, and therefore used the defense of denial of the helpfulness of their relationship with the social worker to relieve their guilt feelings to some degree? Even more important is the question, were these families justified in answering that they had received nothing that had been helpful?

Cottage I had one family who failed to respond to the question

of "what had been most helpful". All families answered this question on Unit A and Cottage II.

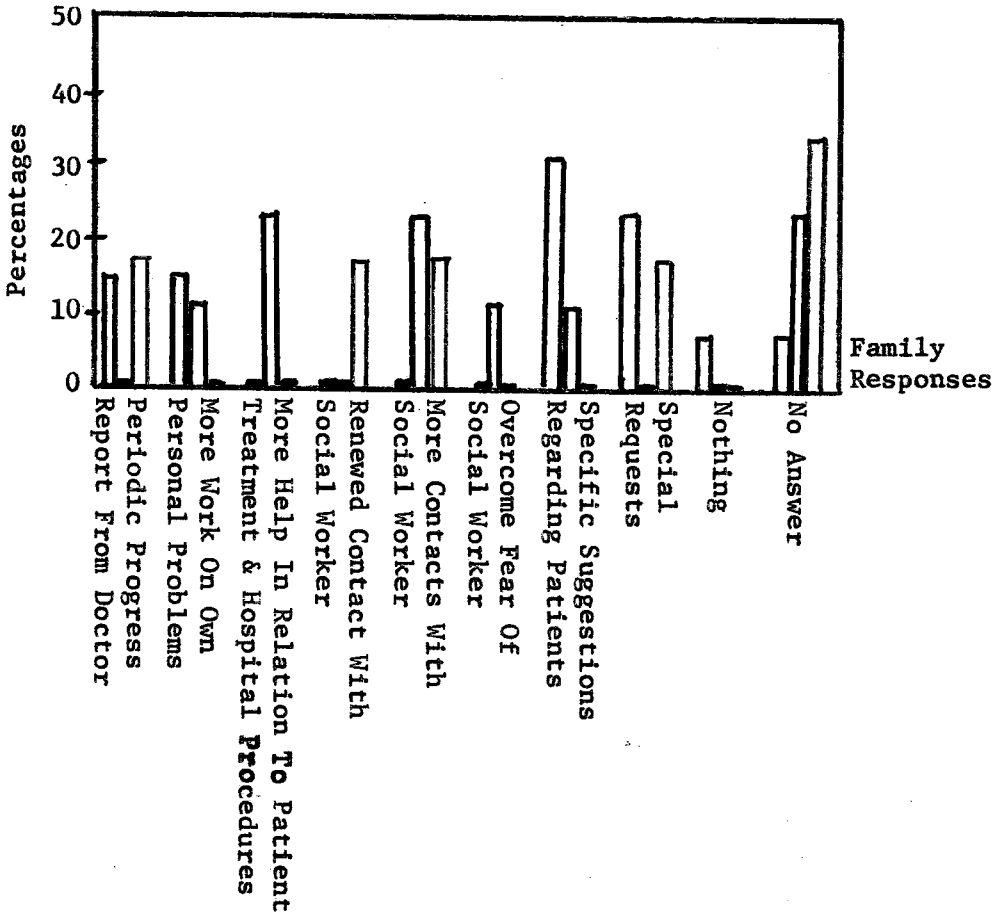
What Would Be More Helpful To You?--In response to this question Figure 26 reveals that the highest peak response from Unit A was in offering "specific suggestions regarding patients". These suggestions related to particular problems of individual patients and therefore are not representative of the group.

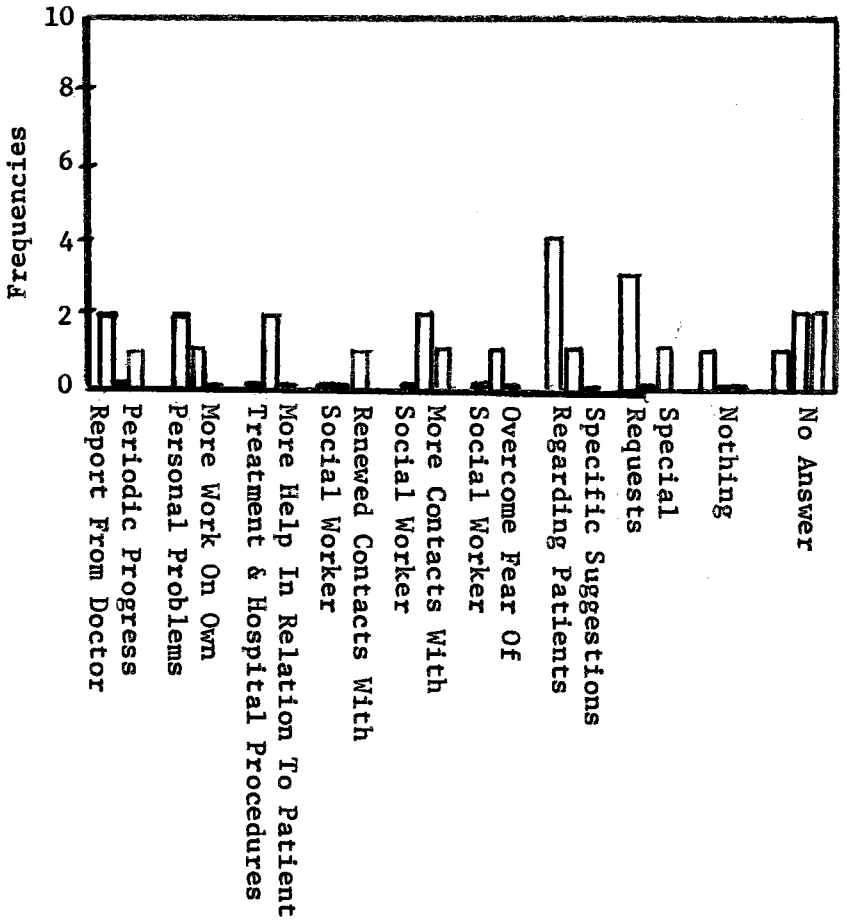
In Cottage I, the largest percentage of families responded in three different areas, "more guidance regarding my relationship with patient, treatment and hospital procedures", "more contact with social worker" and "no answer". The first response mentioned was given only by Cottage I families. In Cottage II the largest percentage of responses was in the "no answer" category.

The second highest response from families on Unit A was in the area of "special requests". These also were individual requests which reflected specific problems particular families were encountering. In Cottage I the second highest peak of responses was in three different areas: "more work with own personal problems", "overcome fear of the social worker" (this response given only in Cottage I) and a "specific suggestion regarding patient". In Cottage II, the second highest response was in four different areas (one family responding in each area). These were: "periodic progress report", "renewed contact with social worker" (response given in Cottage II only), "more contact with social worker" and "special requests" which was for a home visit.

Figure 26 - Social Work Service

What Would Be More Helpful?





Specific Suggestions Regarding Patients: More Relationships And Activities, Being Able To Visit Children, Reminded To Bring Medication on LOA, Taught To Stick With Job And Not Run Away

Special Requests: Involve Family Member Truly Responsible, Appointment Time That Wouldn't Conflict With Work, Financial Assistance, A Home Visit

Key - Units

Unit A ☐ N = 13

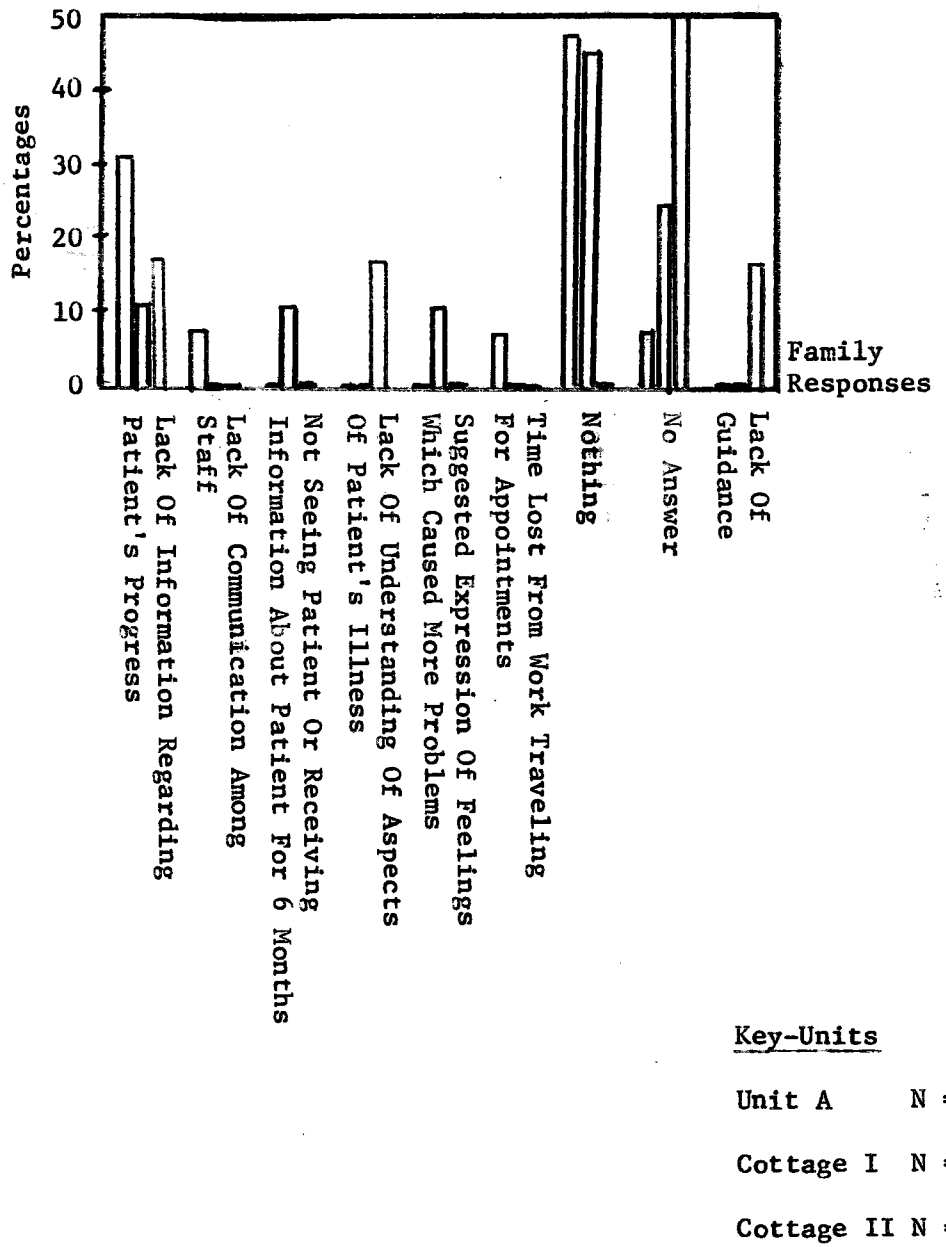
Cottage I ☐ N = 9

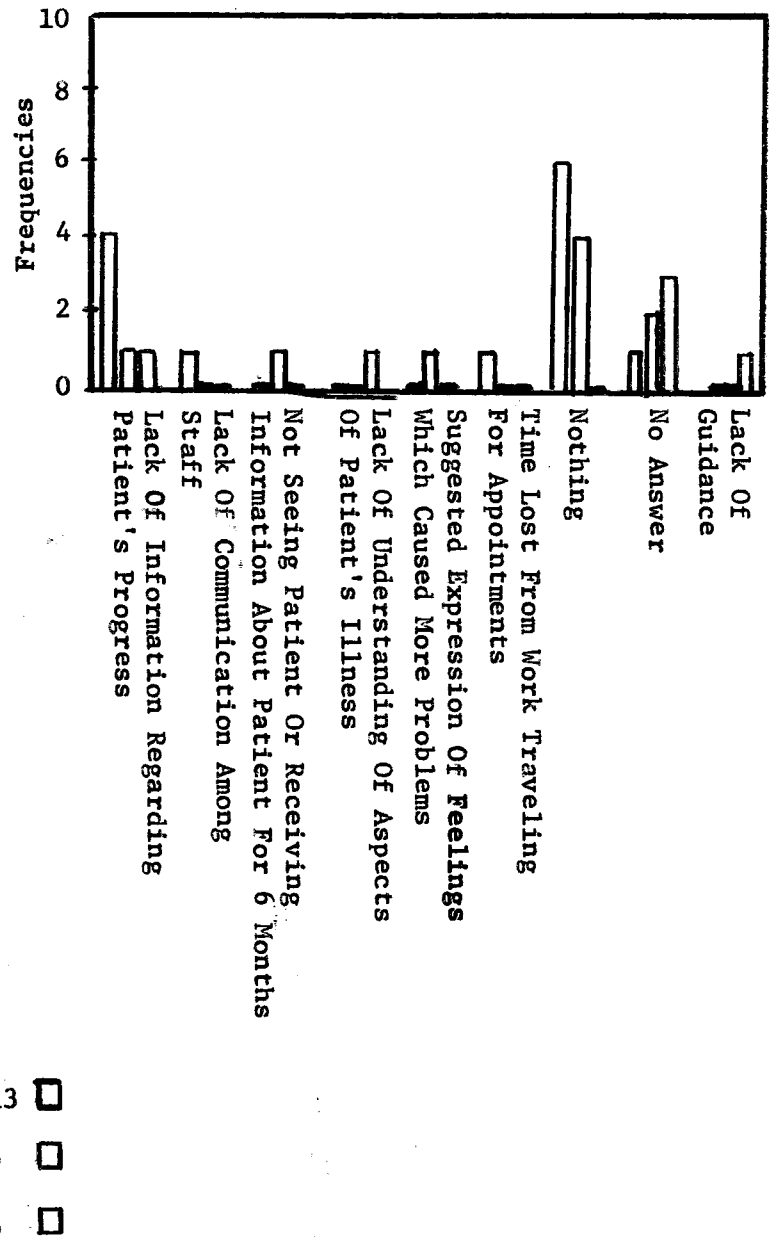
Cottage II ☐ N = 6

What Has Not Been Helpful To You?--In response to this question Figure 27 reveals that the responses of families in all three units were concentrated in the areas of "no answer", "nothing" and "lack of information regarding the patient's progress". The peak response on Unit A and in Cottage I was "nothing" as compared with Cottage II where 50 per cent of the families gave "no answer". The second highest response for Unit A and Cottage II was "lack of information regarding patient's progress", 31 per cent or four families on Unit A as compared with 17 per cent or one family in Cottage II. In Cottage II the same number of families also responded in the categories, "lack of understanding of aspects of patient's illness" and "lack of guidance". These two responses were given by Cottage II families only. Although each is a different response, all are similar in emphasizing the lack in the relationship as perceived by the families. The complaint "lack of information regarding patient's progress" was also given by one family in Cottage I although the second highest percentage of responses for this Cottage was in the "no answer" category. The social worker is the link between the hospitalized patient and his family who anticipates receiving information from the social worker regarding the patient's progress. Many families already have tremendous guilt feelings about their emotionally disturbed member and their own responsibility, real or exaggerated, for his illness. The lack of communication regarding the patient only serves to increase this guilt which becomes an obstacle in establishing a relationship of mutual trust through which resolution of problems can be brought about.

Figure 27 - Social Work Service

What Has Not Been Helpful?





Key-Units

Unit A N = 13

Cottage I N = 9

Cottage II N = 6

The other responses regarding "what has not been helpful" on Unit A were in the areas of "lack of communication among staff", "time lost from work traveling for appointments" and "no answer". The first two responses were from Unit A families only. "Lack of communication among staff" corresponds to one of the complaints registered by patients on Unit A--"staff-doctor contradiction". As previously mentioned, the staff later became aware of this problem and began a sincere effort toward its resolution.

In Cottage I, other responses fell in the area of "lack of information regarding patient's progress", "not seeing patient or receiving report from doctor or social worker for six months" and "suggested expression of feelings which caused more problems". Of these, the first has already been discussed. The response "not seeing patient or receiving report from doctor or social worker for six months" provides the answer for at least one of the responses in the "nothing" category regarding what has been most helpful. In spite of the difficulty which might have been encountered in working with this family, total alienation between the family members might not have been the answer. This aspect is discussed more fully in the analysis of the period variable.

The data collected seems to indicate that there is a greater similarity between all three units in the positive responses to the service received as well as in the negative responses, particularly in at least two areas. One was the "social worker's (Family Counselor's) interest, concern and availability". This positive response received a larger percentage of responses in all three units than did its more negative counterpart "lack of information regarding patient's progress.

Differences between the units in feelings were seen in the areas of "better understanding of own problems as well as patient's", "confident that patient is well cared for" and in the areas "lack of communication among staff", "not seeing patient for six months", "lack of understanding of aspects of patient's problem", "lack of guidance" and "time lost from work traveling for appointments". The units also differed in offering suggestions for improvement of the services. The only similarity between all three units in this regard was in the area of "no answer".

There were similarities between Unit A and Cottage I regarding "what had been most helpful?" in the area of "better understanding of own problems as well as patient's" and between Cottages I and II in the area of "nothing". In regard to "what would be more helpful", Unit A and Cottage II were similar in the response "periodic progress report from doctor", Unit A and Cottage I families desired "more work on own personal problems" and families in Cottages I and II wanted "more frequent contacts with the social worker".

PERIOD OF TREATMENT

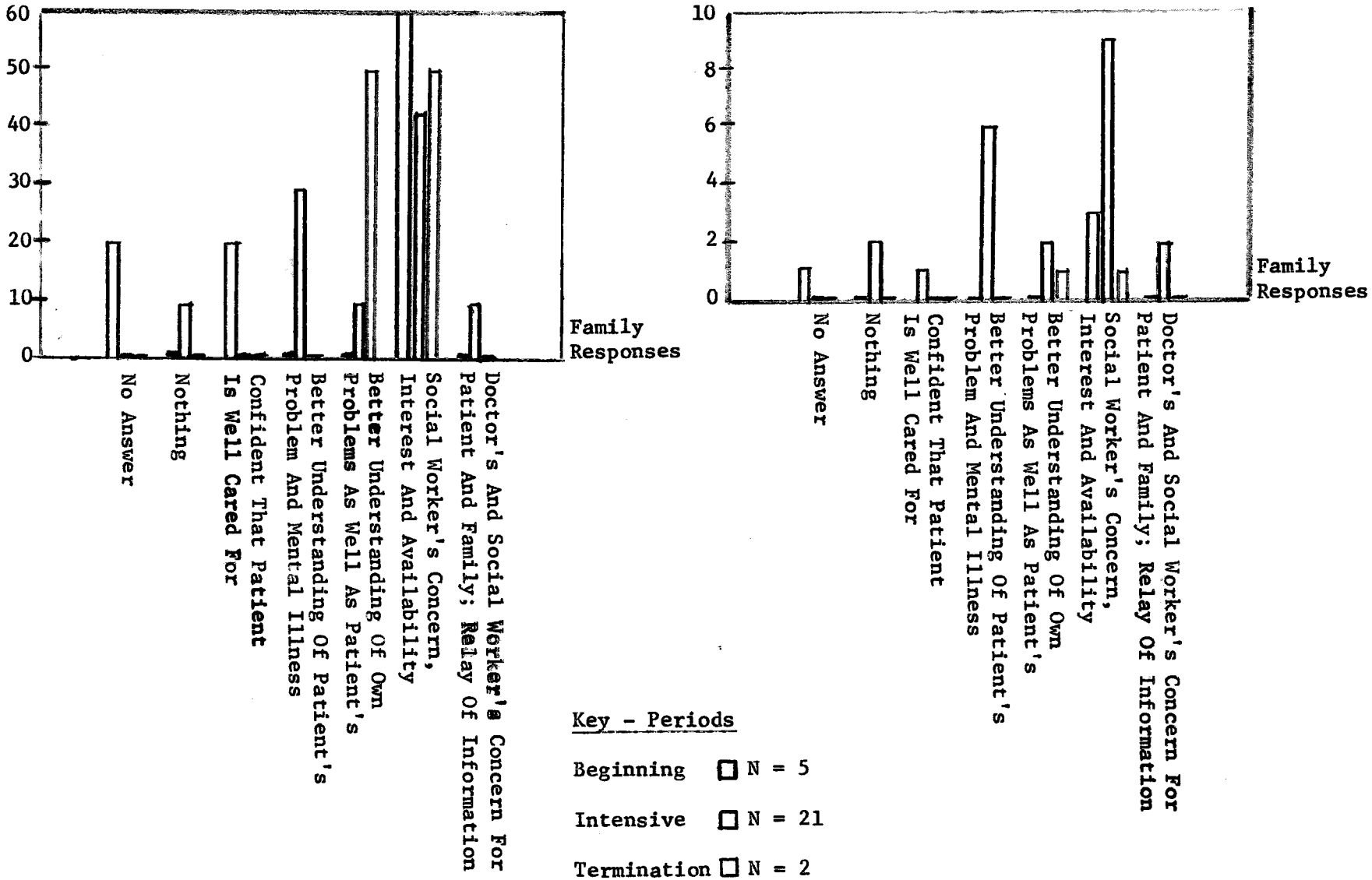
Period as a variable was expected to have some influence on the nature and type of responses families gave to social work service. A large hindrance limiting the researchers' ability to prove or disprove their hypothesis is the difference in the sizes of the samples. The sample for families of patients in the beginning period is five; for intensive period, twenty one; and for termination period, two. If the samples had been closer to the same size, the findings may

have been much more significant. However with major limitation in mind the researchers venture to explore the differences and similarities implied by the data collected. One family received family counseling from a therapist who was not a social worker. Thus family counselor is inserted where necessary. When "beginning period", "intensive period" or "termination period" precedes the word family, it then means that the family has a patient in the beginning period of treatment, intensive period of treatment or termination period of treatment. Since, in most cases, the family begins counseling at the same time the patient begins inpatient treatment, the family itself is actually going through a beginning period of treatment, intensive period of treatment or termination period of treatment in its own right.

What Has Been Most Helpful In Your Relationship With Your Social Worker?--In response to this question Figure 28 illustrates that families with patients within all three periods of treatment mentioned "social worker's (family counselor's) availability, concern, interest and understanding". This response was given by three families with patients in the beginning period of treatment, nine families with patients in intensive treatment, and one family with a patient terminating treatment. One "beginning period" family gave "no answer" and one said "confident that the patient is well-cared for". This latter response was given only by a family of a patient in the beginning period of treatment. This is a major concern for families with patients in the beginning period of treatment. These families feel some relief and gratitude that the patient is receiving professional treatment but nevertheless they are still plagued with guilt feelings around the patient's being in the hospital. The family's emphasis at this point is usually

Figure 28 - Social Work Service

What Has Been Most Helpful?



still on the patient only. The social worker's availability and concern are of major importance during the period of beginning treatment. The family wishes progress reports similar to those they are familiar with in medical hospitals. The social worker's concern for both the patient and the family alleviates some of the family's guilt and anxiety. The understanding and acceptance of the social worker offers alleviation of the feeling held by many families that a family with a mentally ill member is a "bad" family.

With the intensive period families there is a different emphasis. Six family members in this period found "their own better understanding of the patient's problem and mental illness" had been most helpful. This finding indicates the great need families have for being educated about emotional problems. Most families do not understand mental illness and therefore are bewildered, frustrated and terrified by it. Some feel they are to blame. Only with education can the family begin to ease their defenses so that they can understand the patient's problem. Two intensive period families felt that their "better understanding of their own problems as well as the patient's" was most helpful. These families have moved beyond the patient to recognize their own problems and how these problems may relate to the patient's problems. No beginning families gave either of the "better understanding" responses. The two terminating families gave the response of "better understanding of own problems as well as the patient's". The intensive period family begins to gain insight into the family dynamics which involve his own difficulties as well as the patient's. The terminating family has been made aware

that this is an area of major concern. This terminating family's understanding of emotional dynamics has become particularized within the family itself. Thus a trend is seen from the family's distant position of caretaker of the patient, to the family's development of an understanding attitude toward the patient, to the family's direct involvement in the counseling process in a recognition of its own problem as well as the patient's.

Two intensive period families mentioned the doctor as well as the social worker's concern for both patient and family and the good relay of information. The doctors involved deserve to be complimented as one of the most frequent complaints of families is lack of information from doctor. A family often feels the doctor is judging them. The doctor has actually stepped between the family and the patient and this makes the family uncomfortable. The family often needs reassurance by the doctor that he does not feel they are all bad and that he is not going to turn the patient away from them permanently. This reassurance can be done by the doctor's relaying messages through the social worker or by his calling the family once in a while to let them know how the patient is doing. Two families have received this reassurance from the patient's doctor. The less a family feels judged the more they are open to look at their role in the patient's illness.

In contrast to this compliment offered by two families with patients in the intensive period of treatment, two families in this same period said "nothing" had been helpful. In both cases the families involved parents of late adolescent patients. One of these

mothers had not heard from the doctor or social worker for six months. In addition to this she had not been allowed to visit the child during this six months' period. In this particular situation the family member may have been seen as "untreatable" in relation to the patient and needed treatment in her own right. This is a regrettable occurrance, but it does happen. Often the Institute recommends intensive treatment to these particular people but they are not receptive to the suggestion. The doctors may decide to concentrate all efforts on getting the child well in spite of the family or in helping this patient to break away from home. Even if this is the case, some report should be made to the parents periodically. Even the worst parent is concerned about a child even if the worry evolves from guilt. Ignoring the parent completely could present serious problems to the adolescent upon leaving the hospital. These parents are still legally responsible for the child. This particular case is the only one of its kind the researchers encountered in this study.

In the case of the second family who said "nothing" had been helpful, the family was seeing a social worker. However they did not seem satisfied with the relationship. From the nature of this family's response, the researchers got the impression that they were not being seen regularly and would prefer to be seen on a more intensive basis.

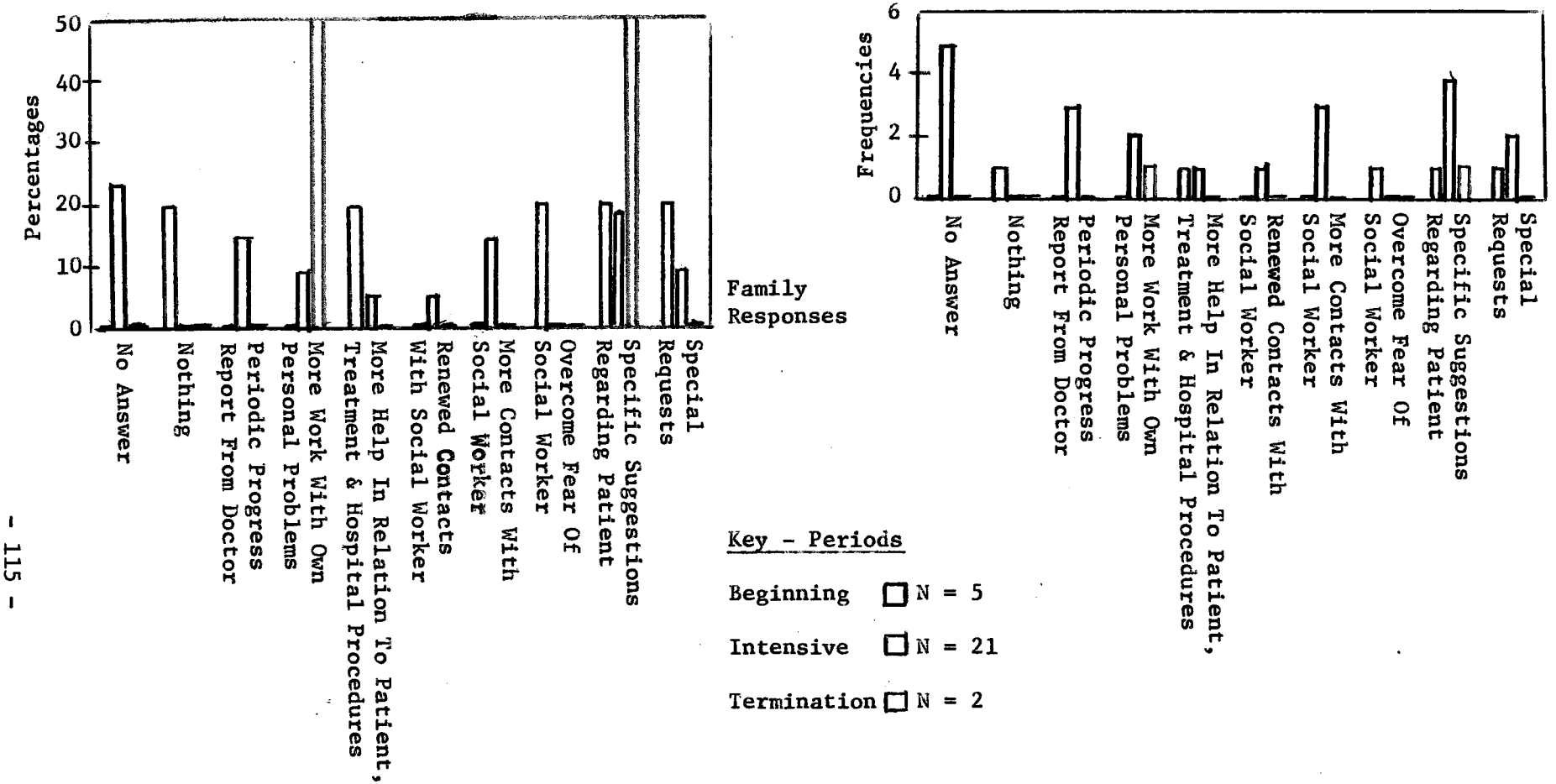
It is particularly noteworthy that both of these families involved parents of late adolescents. Parents are usually directly involved in many different ways with their child's emotional problem. The parents feel extremely guilty when their child becomes sick. They may feel the child is the symbol of unhealthy aspects of themselves. For this

reason parents may be more difficult to work with than the spouse of adult patients. These parents may seek to control the patient, social worker and doctor. They may resist any exposure of themselves. Their guilt may cause them to defend themselves in ways very difficult to break. It is interesting that in the case of the adolescent patients, doctors and social workers may be more ready to exclude the family from treatment than in any other situation. With a child who shall be living with the family, the family is included. With married adults most spouses are included. The adolescent is in a transitional state where he may not be remaining with the family much longer. Also the adolescent is often in rebellion. It could be speculated that a young therapist may still have feelings very close to the adolescent and therefore it is easier to join in an alliance against the parents. It would be interesting to do a study on the therapists' of adolescents attitude toward the parents, the adolescents' attitude toward his parents and the social worker's attitude toward the parents. The social worker too may be more reluctant to tackle the family of an adolescent not only because she may identify more with the adolescent and against the parents, but also because she may wind up on the wrong side of a well-formed alliance. How much the staff's feelings are involved in these two situations is unknown. The above dynamics are mentioned as speculative possibilities.

What Would Be More Helpful To You?--In response to this question Figure 29 shows that families of patients in all three periods of treatment are spread out fairly evenly. The only category which was

Figure 29 - Social Work Service

What Would Be More Helpful?



Special Requests: Involve Family Members Truly Responsible, Appointment Time Not Conflicting With Work, A Home Visit, Financial Assistance.

Specific Suggestions Regarding Patient: More Relationships And Activities, Being Able To Visit Children, Reminded To Bring Medication On LOA, Taught To Stick With A Job And Not Run Away.

mentioned by someone in all three periods was "specific suggestions regarding patients". These suggestions are significant to the family but not to the study, as they related to specific problems of individual patients.

The five families of beginning period patients gave five different responses all of which are fairly typical of families with patients in the beginning period of treatment. These responses were: (1) "nothing needs improving", (2) "more guidance regarding my relationship with the patient, with treatment approach, and hospital procedures", (3) "to overcome fear of social worker", (4) "special requests" and (5) "specific suggestions regarding patients". The comment "overcome fear of social worker" is an honest but rarely admitted one, especially in situations where painful revelations may evolve.

Of the intensive period group five families did not answer at all. This was the only group which fell in the "no answer" category. This is most probably due to the small sizes of the other two groups. The beginning group was the only one to give the most positive response of "nothing" would be more helpful. The terminating family knows more to criticize and has less at stake in doing so. "Periodic progress report from doctor" and "more contacts with social worker" were mentioned by three intensive period families. Several of these families felt out of touch. The need for progress reports or some type of report is mentioned throughout. The intensive period family is struck by a slow pace at which progress is made in mental illness. They often witness relapses and wonder if any progress is being made.

Families are often confused during this period. It is also during this period that both the doctor and the social worker are more likely to fail to keep the family posted because the change is often so gradual. It should be remembered that the family remains concerned and needs to be helped to understand the path of treatment and the vacillating nature of improvement.

Two families in the intensive period mentioned "more work on own personal problems" and two made "special requests". One intensive period family mentioned "more guidance" and another "renewed contacts with social worker". Often due to the shortage of social work staff a family may be terminated before the patient leaves in order that another family may be seen. This is not usually done unless the social worker feels the family is nearing the point where termination will not be harmful.

The terminating families mentioned "specific suggestions" and "more work with own personal problems" in response to "what would be more helpful?" Once again the family member's personal problems are mentioned only by families in the intensive or terminating period. As can be seen the answers for each period are so spread out in regard to "what would be more helpful" that little significance can be attached to the implied differences.

What Has Not Been Helpful To You?--In response to this question Figure 30 reveals that all three period groups had the highest number of responses in the "nothing" category. This category included two beginning families, six intensive period families and both of the terminating

Figure 30 - Social Work Service

What Has Not Been Helpful?

period families. On the other hand, when patients were asked this question they usually gave no response--hence the category "no answer". Perhaps this was a threatening question, but the number of "nothing" responses by patients and families is still surprising. "Nothing" is a very committed response to this question. The only specific criticism which had more than one person mentioning it was "lack of information regarding patient's progress". This was mentioned by two beginning period families and four intensive period families. This has been a concern of intensive period families throughout the study. This may be an indication that the social worker is not keeping the family posted or the family has not been helped to understand that clear indicators of progress are not always visible in mental illness. Possibly, as mentioned before, the family wants to hear the report directly from the doctor who is treating the patient. Another possibility is that there is poor communication between the social worker and doctor so that information is not relayed and there is not clear understanding of how much the doctor wishes the family to know.

From the data collected in our study, the samples are too irregular to indicate whether or not period is a significant variable. Nevertheless the beginning period families seem more concerned with patient problems and the more superficial aspects of the social work service and on the whole see themselves as relatively unrelated to the patient's problem. As families move through the intensive and terminating periods their responses show first an increased understanding of

mental illness and the nature of the patient's difficulty and then an increased awareness of their own problems and the overall family dynamics of which the patient is a part. The beginning period families and particularly the intensive period families are concerned with receiving information regarding the patient and desiring periodic progress reports. Both beginning period families and intensive period families desired more guidance. They desire a less nondirective approach from the social worker. The families in both of these periods are frustrated by the lack of magic answers and clear cut prescriptions for curing the patient's illness. In treating mental illness there are no prescriptions of aspirin four times daily, or penicillin shots or wonder drugs. Consequently families feel more helpless in the face of mental illness than organic illnesses. Often habits or emotional blockings on the part of family members need to be worked through before advice would have a chance of being implemented in the dynamics of a particular family situation. Perhaps guidelines in very simple areas do need to be given so that the family has something to hold on to as it moves through the complexities of the counseling process in which it is involved.

DIAGNOSIS

The diagnosis of the patient does not seem to act as a significant variable in effecting the patient's family's responses to social work service. The samples included: twelve families of schizophrenic patients, ten families of depressed patients, four families of adolescent adjustment reaction patients, and one family of a sociopath. Both

parents of one adolescent patient filled out separate questionnaires, therefore there are five responses in this diagnostic group. No significant differences were found between depressed patient's families and schizophrenic patients' families. These are the only two samples similar enough in size to make an accurate comparison.

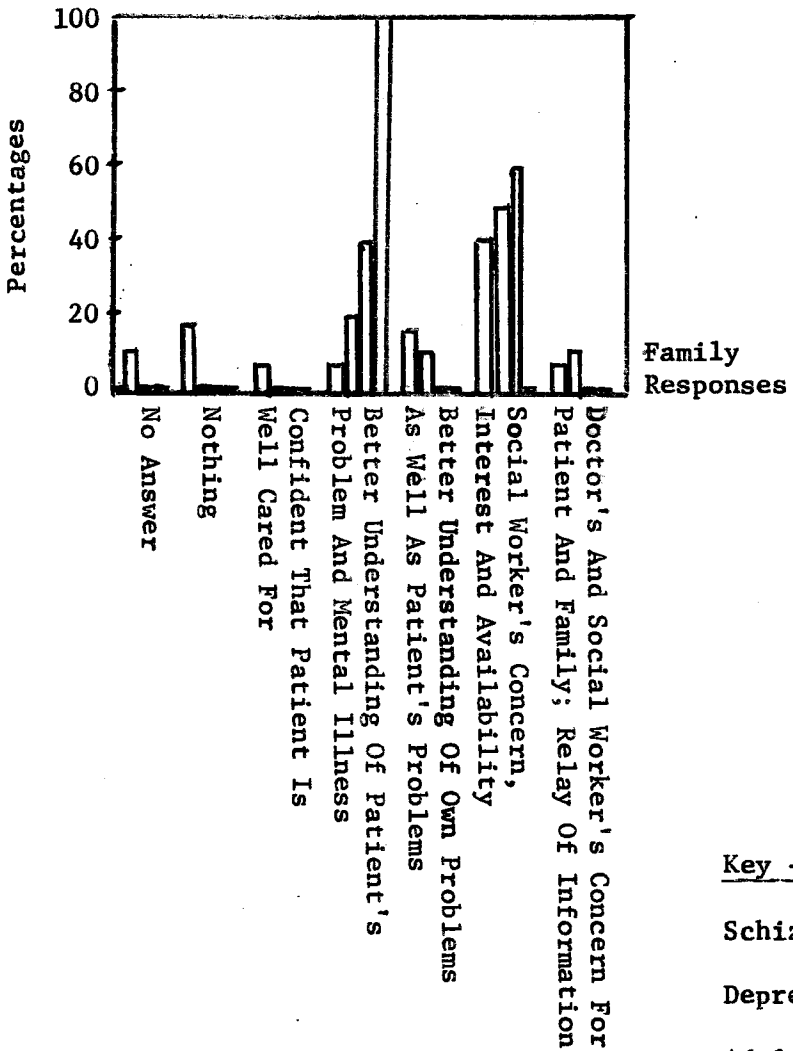
What Has Been Most Helpful To You?--In response to this question Figure 31 shows that five families of schizophrenics and five families of depressed patients answered "the social worker's (family counselor's) availability, concern, interest and understanding".

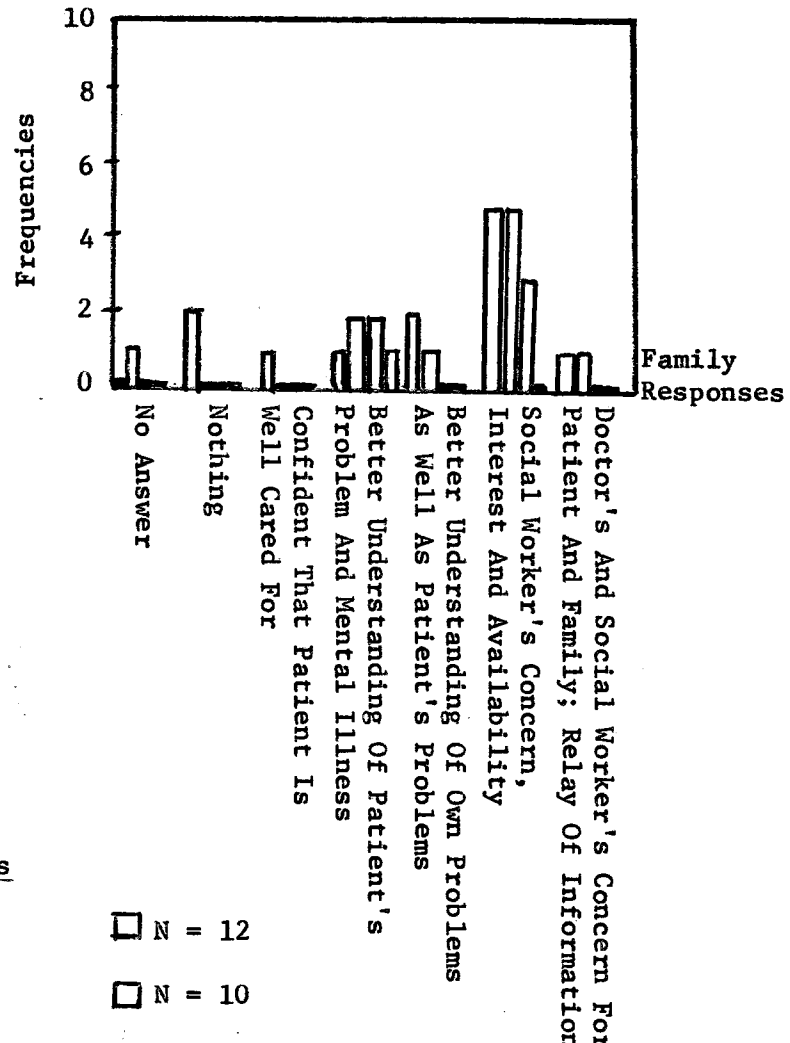
"Better understanding of own problems as well as patients" was mentioned by two families of schizophrenics and one family of a depressed patient as being most helpful. "More work with own personal problems" was suggested by two families of depressed patients and one family of a schizophrenic for "what would be more helpful?" Thus families within both diagnostic categories seem equally aware and concerned with their own problems as well as those of the patient.

One family of a schizophrenic patient and two families of depressed patients mentioned "better understanding of patient's problem and mental illness". The depressed patients' families showed their interest in this area when they suggested "more guidance regarding my relationship with patient, treatment process and hospital procedures". Once again this area of concern for understanding emotional illness does not appear to be determined by the diagnostic factor but is a common concern shared by families regardless of the diagnosis of the patient.

Figure 31 - Social Work Service

What Has Been Most Helpful?





Key - Diagnosis

Schizophrenia	N = 12
Depressed	N = 10
Adolescent Adjustment Reaction	N = 5
Sociopath	N = 1

What Would Be More Helpful To You?-- In response to this question Figure 32 reveals that the answers for families falling in all diagnostic categories are so spread out that no significant conclusions can be drawn. Only families of schizophrenic patients mentioned "renewed contacts with social worker" and "more contacts with the social worker". These families desire to be involved and to receive more intensive counseling. This is a quantitative expression of improvement with the relationship. The depressed patient's family's suggestion for "more guidance" and "overcoming fear of social worker" are qualitative suggestions for improvements.

Although only one depressed patient's family mentioned "a periodic progress report from doctor" in answering this question the families of schizophrenic patients revealed a similar interest in this area when in response to "what has not been helpful?" five families of schizophrenics said "lack of information regarding patient's progress". Three of the five family members of patients with an adolescent adjustment reaction also expressed dissatisfaction with the lack of information regarding the patient's progress or the need for periodic progress reports from the doctor. This is obviously a concern shared by families regardless of the diagnosis of the patient's illness.

What Has Not Been Helpful To You?--In response to this question Figure 33 illustrates that the majority of families of schizophrenic patients answered "lack of information regarding patient's progress".

Figure 32 - Social Work Service

Diagnosis Variable - What Would Be More Helpful?

Family Responses	Schiz.		Dep.		A.A.R.		Sociopath	
	f	%	f	%	f	%	f	%
Specific Suggestions Regarding Patients: More Relationships & Activities, Being Able To Visit Children, Reminded To Bring Medication On LOA, Taught To Stick With Job And Not Run Away	3	25	2	20	0	0	1	100
Overcome Fear Of Social Worker	0	0	1	10	0	0	0	0
More Contacts With Social Worker	2	16.7	0	0	1	20	0	0
Renewed Contacts With Social Worker	1	8.3	0	0	0	0	0	0
Special Requests: Involve Family Member Truly Responsible, Appointment Time That Wouldn't Conflict With Work, Financial Assistance, A Home Visit	2	16.7	0	0	1	20	0	0
More Work On Own Personal Problems	1	8.3	2	20	0	0	0	0
More Help In Relation To Patient, Treatment And Hospital Procedures	0	0	2	20	0	0	0	0
Periodic Progress Report From Doctor	0	0	1	10	2	40	0	0
Nothing	0	0	1	10	0	0	0	0
No Answer	3	25	1	10	1	20	0	0
	N = 12		N = 10		N = 5		N = 1	

Key - Diagnosis

Schiz. = Schizophrenia
Dep. = Depressed
A.A.R. = Adolescent Adjustment Reaction

Figure 33 - Social Work Service

Diagnosis Variable - What Has Not Been Helpful?

Family Responses	Schiz.		Dep.		A.A.R.		Sociopath	
	f	%	f	%	f	%	f	%
Time Lost From Work Traveling For Appointments	1	8.3	0	0	0	0	0	0
Suggested Expression Of My Feelings Which Caused More Problems	0	0	1	10	0	0	0	0
Not Understanding Aspects Of Patient's Illness	1	8.3	0	0	0	0	0	0
Not Seeing Patient Or Receiving Report About Patient For 6 Months	1	8.3	0	0	0	0	0	0
Lack Of Communication Among Staff	0	0	0	0	1	20	0	0
Lack Of Information Regarding Patient's Progress	5	41.7	0	0	1	20	0	0
Lack Of Guidance	0	0	1	10	0	0	0	0
Nothing	2	16.7	5	50	2	40	1	100
No Answer	2	16.7	3	30	1	20	0	0
	N = 12		N = 10		N = 5		N = 1	

Key - Diagnosis

Schiz. = Schizophrenia
Dep. = Depressed
A.A.R. = Adolescent Adjustment Reaction

The largest percentage of families of depressed patients answered "nothing" or gave "no answer".

The families of adolescent adjustment reaction patients found the "social worker's availability, interest, concern and understanding" and their "better understanding of patient's problem and mental illness" as most helpful. These feelings were shared and not distinct from the families of schizophrenic and depressed patients. In response to "what would be more helpful?" two families of adolescents said "periodic progress report from doctor", one said "renewed contacts with the social worker", one said "special requests" and one gave "no answer." Notably absent among these families is any concern for understanding their own problems. This is a threatening area for parents which is usually well protected because of the strong guilt feelings and anxiety. This also reveals an attitude often found among adults that children's problems are unrelated to adults and that they will grow out of them. In response to the last question "what has not been helpful?" one family of a patient with adolescent adjustment reaction gave "no answer", one said "lack of information regarding patient's progress", and another "lack of communication between staff members". Two of these families said "nothing".

The grandfather of the sociopath said that his "better understanding of the patient's problem and mental illness" had been most helpful. He made the special suggestion that if the patient were made to stick it out on a job it would be more helpful. To this man "nothing" had not been helpful.

From the data it can be seen that a patient's diagnosis effects very little of the social work service desired by the family.

SEX

There is such a wide variation between the number of families studied as far as sex of the patient is concerned (twenty-three families of female patients and five families of male patients) no explicit conclusions can be drawn from this study. In spite of the wide difference between the sample sizes, the responses received from the families of both sexes seem to indicate that the sex of the patient has little significance in the family's relationship with the social worker.

What Has Been Most Helpful To You?--In response to this question the peak response for families of female patients was in the area of "social worker's (family counselor's) concern, interest and availability". Figure 34 indicates that two families of male patients gave this response and also "better understanding of patient's problem and mental illness". The latter answer was the second highest peak response for families of female patients. One male patient's family and two female patients' families answered that "better understanding of own problems as well as patients problem", had been most helpful. Two families of female patients responded in each of the categories, "interest and concern of the doctor and social worker; relay of information" and "nothing" which are at opposite ends of the pole. One family of a female patient answered "confident patient is well-cared for" as being most helpful and one

Figure 34 - Social Work Service

What Has Been Most Helpful?

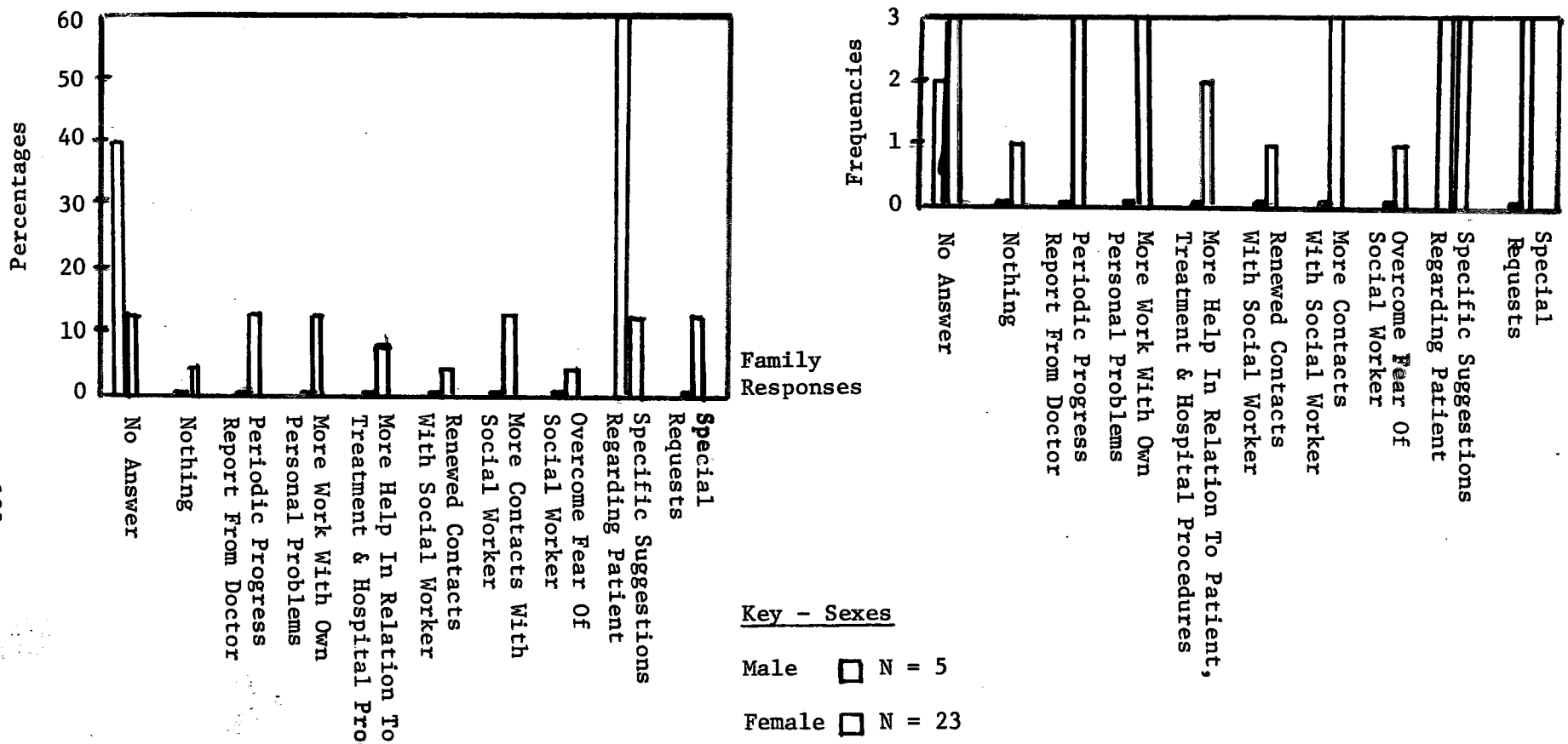
failed to respond to this question.

What Would Be More Helpful To You?--In response to this question, Figure 35 shows that three families of male patients gave "specific suggestions regarding patient" and two did not respond. The responses from the families of female patients were spread out with three responses in each of the following categories: "no answer", "periodic progress report from doctor", "more work with own personal problems", "more contacts with social worker", "special suggestions regarding a particular patient" and "special requests". Two families desired "more guidance regarding my relationship with patient, treatment and hospital procedures". One family answered in each of the categories: "nothing", "renewed contacts with social worker" and "overcome fear of the social worker".

What Has Not Been Helpful To You?--Figure 36 shows that the majority of families of both sexes felt that everything had been helpful. On the other hand, six families of female patients failed to answer. Considering the threatening element of this question and the large number of families of female patients failing to respond, one might ask: were the families of the female patients fearful of being rejected or of reprisal for their patient member who was still hospitalized if criticism was offered? Or did these families have no criticism to offer? This seems unlikely as a positive response of nothing would probably have been given had this been true. In this same area one might also speculate that the male patients' families felt that everything had been helpful. This is indicated

Figure 35 - Social Work Service

What Would Be More Helpful?

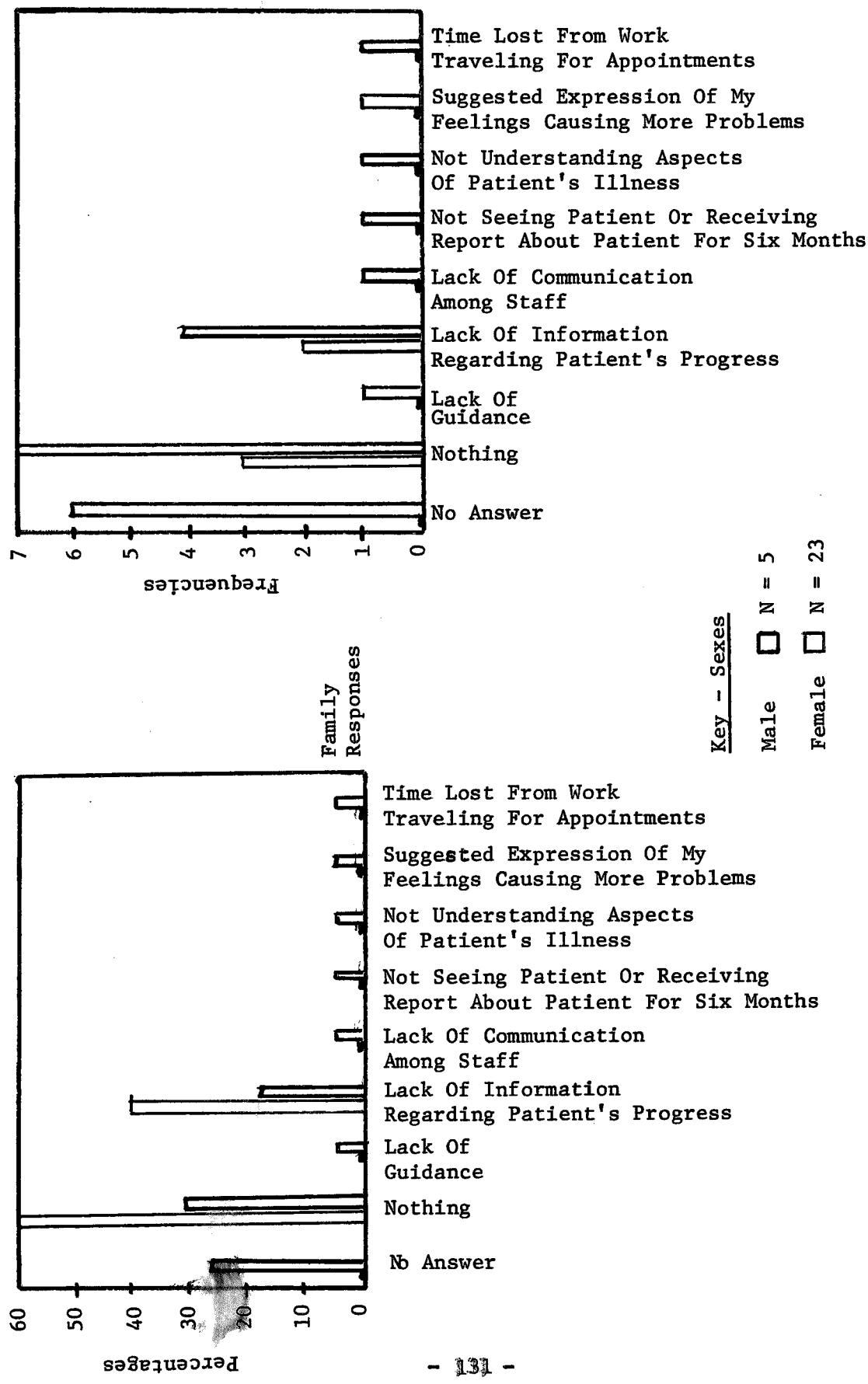


Special Requests: Involve Family Members Truly Responsible, Appointment Time Not Conflicting With Work, Financial Assistance, A Home Visit

Specific Suggestions Regarding Patient: More Relationships And Activities, Being Able To Visit Children, Reminded To Bring Medication On LOA, Taught To Stick With A Job And Not Run Away

Figure 36 - Social Work Service

What Has Not Been Helpful?



by the fact that three out of five families of male patients answered "nothing" to the question, "what has not been helpful?" Both families of female as well as male patients answered "lack of information regarding patient's progress" had not been helpful. The fact that the families of both sexes answered in this category indicates that sex is not a significant variable in the families' desire to receive information regarding the patient. The balance of the responses from the families of the female patients were equally spread out in the following areas: "lack of guidance", "lack of communication between staff", "not seeing patient or receiving information regarding patient from doctor or social worker for six months", "not understanding aspects of patient's illness", "suggested expression of feelings caused more problems", and "time lost from work travelling for appointments".

In general the sex of the patient seems to have little significance in the family's evaluation of the services received. The families of both sexes feel that the social worker's (Family Counselor's) interest, concern, understanding and availability to them are important aspects in the social worker-family relationship. The families of both sexes indicated an awareness of the patient's problem and mental illness as being most helpful as well as an awareness of their own problems as well as patient's. The families of both sexes offered specific suggestions regarding improvement in the services and the families of both sexes gave similar responses regarding what had not been helpful, i.e. "nothing"or "lack of information regarding patient's progress".

CHAPTER V

SUMMARY AND CONCLUSIONS

SUMMARY OF THE FINDINGS

(1) In relation to individual therapy patients in all three units emphasized the personal as opposed to the professional quality of the relationship. However 75 per cent of the patients in Cottage II felt the lack of the personal quality as expressed by their voicing the need to feel that the therapist cared for them, while only 35 per cent of Cottage I patients and 32 per cent of Unit A patients expressed this need. Unit A patients were the only ones to express the non-beneficial effect of staff-doctor contradiction. Cottage I seemed to be the most well balanced unit as the data shows no specific complaints or suggestions unique to this unit. The other three variables, sex, diagnosis and period, did not make a significant difference in the ways in which the patients responded to their one-to-one therapeutic relationship. Still the fact remains that in this study the major concern of the patients regardless of the four variables is with the personal quality of the therapist as expressed by his understanding, concern, warm response, acceptance and respect for the patients.

(2) In relation to milieu therapy the variables tended to make a difference in certain areas. However only those differences resulting from the unit variable can be regarded as actually significant since only their sample sizes were similar. Since the sample sizes

of period of treatment, diagnosis and sex were so divergent, no conclusive statement regarding the significance of the differences can be made. Regarding group activities, patient meetings received negative responses from patients in Unit A and Cottage I. The only schizophrenic patient mentioning patient meetings found them most helpful while the depressed patients who mentioned patient meetings found them unhelpful. The sex and period variables made no difference in relation to patient meetings or group activities.

In relation to the number of patients who gave no answer to the questions concerning individual therapy the sex, unit, and diagnosis variables made a difference while period did not. More females than males did not answer. Regarding the response of "lack of close relationships" as being unhelpful, unit, diagnosis and period made a difference while sex did not. This response was given only by beginning and intensive period depressed patients in Cottage II. Females on Unit A were the only patients to mention staff-doctor contradiction. Period and diagnosis did not effect this response. The only responses given by Cottage I patients concerning vocational rehabilitation were the suggestion for more intensive vocational rehabilitation counseling and the complaint that the experience with vocational rehabilitation was not helpful. Patients from Unit A and Cottage II mentioned vocational rehabilitation as most helpful. Sex also seemed to make a difference as only female patients mentioned vocational rehabilitation in any way. Most significant is that patients, regardless of the four variables, shared appreciation, interest and

concern for the personal relationships with both patients and staff. Patients in general showed appreciation for the three specialized therapies, occupational therapy, music therapy and recreational therapy, and patients across the board expressed a desire for "more spare time" activities and "weekend activities."

(3) In relation to social work service, the families in general valued "the social worker's interest, concern, availability and understanding" and the "better understanding they had acquired of the patient's problem and mental illness." The major complaint shared by families was the "lack of information regarding the patient's progress." The sex, diagnosis, unit or period of treatment of the patient did not significantly influence the families' feelings toward social work service.

(4) In general in all three areas of service the major emphasis was on the personal and supportive qualities of relationships. This emphasis was expressed by patients and families regardless of the four variables considered in this study.

DISCUSSION OF FINDINGS REGARDING INDIVIDUAL THERAPY

One of the findings involved the need of patients in general for a "more supportive less authoritarian" and "more supportive as opposed to a nondirective" relationship with their therapists. One variable that may have influenced these responses is socioeconomic class. Basing social class on the index of income, occupation and education, H. Aronson and B. Overall tested the following hypotheses:

> lower class patients, in comparison with middle class patients, will anticipate the therapist to be (1) more medically oriented (2) more active or directive (3) more supportive, and thus will expect the therapist to be (4) less passive, and (5) less interested in psychological, i.e., emotional or interpersonal, material.[1]

Their data significantly supported hypotheses two, three and four although not one and five. According to their findings, socio-economic status may have influenced the responses of patients in our study. However the analogy is cut short because Aronson's and Overall's study deals with patient expectations while this study examines the helpful and nonhelpful aspects of a therapeutic relationship already in operation. Thus this study is dealing with a latter phase in treatment than that of expectation. Their study asked the question "what do you expect or desire in a psychotherapeutic relationship?" While this study asked the question "what within the psychotherapeutic relationship is actually helpful or unhelpful to you?"

With the above question in mind, it is necessary to look at the "supportive as opposed to nondirective" and "supportive less authoritarian" responses in the light of Allport's theory which he feels is applicable to the therapeutic relationship regardless of the social class of the patient. Allport sees the need for a blending of the best elements of the two extremes of the nondirective approach

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[1] H. Aronson and Betty Overall, "Treatment Expectations of Patients in Two Social Classes," Social Work, XI (January, 1966), 36.

and the directive approach. In the nondirective approach he sees the client telling the therapist about himself and his feelings while the therapist acts as a mirror reflecting the patient's feelings, self-image, et. al. In this type of relationship the patient is the primary participant and the therapist shares little of his own feelings and personality. In the directive approach the interaction is overbalanced in the direction of the counselor who, with a generalized picture of the patient, gives advice regarding the patients particular problem. This type of relationship, although perhaps appropriate in short term, crisis or environmental manipulation circumstances, often inhibits the expression of underlying feelings. The counselor is not related to as a person but as a person with a useful function. The client is not allowed to share of himself but rather the focus is on a particular overt problem.[1]

In Allport's suggested perception of the counseling problem, he sees the client as the expert on his personal feelings and the counselor as the expert on feelings in general. Between the counselor and patient he sees the necessity for mutual warmth and respect. Both the counselor and patient express their feelings with the patients' focus on search and evaluation and the counselor's focus on consultive assistance.[2] This approach not only allows for the patient's right to self-determination (i.e. making his own decisions about his life course) but also gives

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[1] Gordon W. Allport, "Psychological Models For Guidance", Harvard Educational Review, XXXII (Fall, 1962), 373-381.

[2] Ibid.

the patient the opportunity to experience, to try and to learn healthy interaction with another person. The counselor becomes a person rather than a professional with a wealth of knowledge. The knowledge becomes an integrated part of the counselor and is expressed through feelings.

This theory speaks to the emphasis of patients in this study on the personal quality of the relationship rather than on the professional excellence. It speaks to the responses desiring "a warmer response" from the doctor, "more supportive less nondirective" and the "lack of feeling" response to "what had not been helpful?"

Carl Rogers'most recent theory would support Allport's move toward having the therapist relate more as a person. It must be noted that prior to 1956 Carl Rogers was a strict advocate of non-directive, reflective, client-centered counseling. This theoretical approach was spelled out in his book Counseling and Psychotherapy.[1] In contrast to this earlier strictly nondirective approach Carl Rogers wrote in 1957:

> ... the therapist should be within the confines of (the therapeutic) relationship a congruent, genuine, integrated person ... It is not necessary...that the therapist be a paragon of wholeness in every aspect of his life. It is sufficient that he is accurately himself... It should be clear that this includes being himself even in ways which are not regarded as ideal for psychotherapy.[2]

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[1] Carl R. Rogers, Counseling and Psychotherapy (Massachusetts: The Riverside Press, 1942).

[2] Carl R. Rogers, "The Necessary and Sufficient Conditions of Therapeutic Personality Change," Journal of Consulting Psychology, XXI (1957), 97.

Here he makes it absolutely clear that the therapist relate as a genuine person. He says that the focus is on the patient's feelings but the therapist should also state his. Most persons with emotional problems have a basic difficulty in relating with other persons. Thus the therapist needs to respond as a person so that the patient can learn ways to relate to other persons in more satisfying ways. The patient learns this only if the therapist shares his real self.

Rogers in 1961 draws even tighter the necessity for the therapist's responding with his real self. This is expressed in the following passage:

> the more the client perceives the therapist as real or genuine, as empathetic, as having an unconditional regard for him, the more the client will move away from a static, unfeeling, fixed, impersonal type of functioning and the more he will move toward a way of functioning which is marked by a fluid, changing, acceptant experiencing of differentiated personal feelings.[1]

The existential psychological school of thought reaffirms this approach of person-centered therapy. This is expressed in the following passage:

> It is expected that the relationship with the therapist is the meeting of two live, real human beings, with the therapist fully present to his client... It is a living together in communication that breaks the isolation of the patient...both the therapist and the patient

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[1] Carl R. Rogers, "The Process Equation of Psychotherapy" American Journal of Psychotherapy, XV (1961), 44.

> appear as individuals who are becoming...[1]
> (in the process of self-actualization)

The patient in psychotherapy is in the process of becoming an integrated person. Every human being is in this process, but the patient is having more of a struggle. To demand that a patient be more of a real person while the therapist becomes less of one through the protection of professional distance is a contradiction. It is also contradictory and ironical that a patient participate as personally as possible while the therapist remains impersonal and detached. The expression of self on the part of one person both supports and provides a model for another to express himself with less fear. An individual moves along the road of becoming a person by interacting with other real persons not by interacting with functions (i.e. only the functional aspects of others). It must be recognized that being personal does not mean the therapist needs to become overly involved or needs to enter into the relationship to the extent of feeling like the patient. This would not be a sharing of the real self of the therapist. Rather the therapist's feelings are focused on his concern, respect and desire to assist the patient who is struggling. The therapist's focus is not on the exploration of his own personality, but this does not mean he cannot be personal.

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[1] Carl R. Rogers, Book Review of Rollo May, Ernest Angel and Henri F. Ellenberger's, The Way To Do Is To Be in Contemporary Psychology: A Journal of Reviews, IV (July, 1959), 197.

It would seem that the fears of becoming overly involved to the point of taking on the patient's problem as one's own and of unconsciously rejuggling the focus to the therapist's own personality led to the devised protection of professional distance in nondirective counseling. This distance of impersonal quality can be as unhelpful as the over involvement. It would seem the true skill of counseling would require the therapist to be well enough reconciled with himself that he need not protect himself to the degree of remaining detached but could share his feelings with the patient in a real and genuine way so that the patient can perceive the therapist's concern and respect for him.

The impersonal quality of acting only as a mirror was used also to reinforce the nonjudgmental attitude of the therapist. However this type of detachment to these researchers seems judgmental in itself--not of anything the patient says or does but of the person as a whole. It is saying to the patient that he is judged unworthy of the therapist's personal interaction. Patients before entering treatment often faced detachment on the part of others towards them. The therapist's similar response further engenders in the patient the feeling of alienation and low self worth.

From the data of this study, the researchers conclude that patients regardless of sex, diagnosis, unit or period of treatment tend to want their therapist to respond more as a person. These feelings have been recognized by the above mentioned writers and require serious consideration by any therapist or counselor who deals

with other people.

DISCUSSION OF FINDING REGARDING MILIEU THERAPY

In relation to their life at the institute patients in general emphasized the friendly and supportive relationships they had with staff and patients. Thus, as in individual therapy, there is a desire for and appreciation of the person-centered quality of the milieu. Both on Unit A and Cottage II certain patients ran into difficulty in their relationship with staff.

Certain Unit A patients mentioned the disagreeable effects of "staff-doctor contradiction" or "the lack of a unified approach" among the staff team members. Arthur Gladstone and Donald Burnham have done an interesting study in the area of hidden staff disagreement.[1] From their data they found that "acknowledged staff disagreement and patient excitement did not go together" but that "unacknowledged or hidden disagreement and high excitement did correlate."[2] The possibility of hidden staff disagreement should be investigated on Unit A. This disunified approach is more likely related to hidden staff disagreement than to acknowledged disagreement. Disagreement which is acknowledged can usually be dealt with openly and controls and checks for disunity can be set up informally or formally. It is the hidden disagreement which tends to permeate one's actions and therefore be more subtle to staff. However the patient picks up the subtlety because the

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1 Arthur I. Gladstone and Donald L. Burnham, "A Method of Studying the Relationship Between Pathological Excitement and Hidden Staff Disagreement," Psychiatry: Journal of the Study of Interpersonal Processes, XXIX (November, 1966), 339-343.

2 Ibid, 342.

impact of the combined subtle differences may not be subtle, but obvious. The staff-doctor contradiction may well be related to hidden disagreement.

In Cottage I no one mentioned "staff-coctor contradiction" or "lack of close relationships". The staff members in Cottage I seemed to respect one another and there is more freedom and flexibility in each profession's being able to use its knowledge and to experiment with its techniques. For example, the chaplains hold religious discussions to which families of patients are also invited. A psychologist is conducting psychodrama in which both patients and staff participate. Two other psychologists are trying new techniques in treating patients and have been quite successful in the cases of two phobic patients. Social workers are primary therapists of inpatients and they also work as co-therapists with psychologists or psychiatrists in group therapy. The staff within this cottage was one of the first to move into the community on a consulting basis. Where this much freedom to express and to experiment exists, there is likely to be less hidden disagreement and more of a unified approach in which each of the different types of professionals is respected and appreciated for what he or she can offer to the treatment setting. The different professionals are more likely to be operating on similar levels in which the vertical element of status hierarchy is decreased.

This brings one to the findings of Robert Perruci in his study on "Social Distance, Bargaining Power, and Compliance with Rules

on a Hospital Ward."[1] His findings may possibly be applicable to Unit A in relation to "staff-doctor contradiction" and to Cottage II in relation to the "lack of close relationships." Further investigation only would determine the actual application of Perucci's findings in these two units. He found that "the attendants compliance with rules and directives were determined, on the ward studied, largely by the patterns of social distance between the occupants of the various positions and the power relationships between the subordinates and superordinates."[2]

He sees two types of knowledge as factors related to the degree of social distance between different members of the staff and patients: (1) knowledge about positions or public symbols and (2) knowledge about persons occupying positions or private symbols. The more the private symbols are shared the lesser the degree of social distance. Where a highly vertical hierarchy exists, there is greater social distance between staff members and between staff and patients. This distance is perpetuated by the struggle of individuals to advance their position by either "minimizing social distance from persons higher in the hierarchy, or maximizing social distance from persons lower in the hierarchy."[3] Where this type hierarchy exists whether overt or covert, the patients are likely to experience fewer close relationships with staff and are likely to experience contradiction among staff members who are competing

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[1] Robert Perruci, "Social Distance, Bargaining Power and Compliance with Rules on a Hospital Ward," Psychiatry: Journal for the Study of Interpersonal Processes, XXIX (February, 1966), 42-55.

[2] Ibid., 42.

[3] Ibid., 53.

with one another. Where there is little respect by a person in a higher position on the hierarchy for a person in a lower position, the person holding the higher position is not likely to get a good response from the latter. For example when a doctor assumes all responsibility and uses the nurse as an ignorant flunky, he is not going to get a good response from the nurse.

Because of the complications evolving from a vertical hierarchy in which there is a lack of mutual respect, Robert Perruci sees the team approach as more effective in treatment and less entangled in status struggle. The question needs to be asked whether in Unit A and Cottage II there is a subtle or covert vertical hierarchy underlying the supposed team relationship. If the team relationship does exist, many patients are not feeling the advantages of this approach as expressed by Robert Perruci:

> (1) Patients not subjected to differing sets of expectations regarding appropriate behavior.
>
> (2) Specialized treatment offered by different staff may be coordinated so as to eliminate internal contradictions.[1]

A third patient advantage that might be stated would be closer feeling toward staff members.

Perruci sees the advantages of a team approach to staff involving the following:

> (1) Staff members, particularly lower ones, acquire greater commitment to work by being a part of the therapeutic function.

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[1] Ibid., 49.

(2) Everyone is encouraged to give ideas and observations.

(3) Criticism and disagreement are encouraged.

(4) Everyone shares more of personal life thereby breaking down rigid, distance creating formality.[1]

The team approach fosters communication among staff and encourages the use of talents of each of the staff members. These talents are inhibited when their expression involves a different approach from the top man in a vertical hierarchy rather than a team. As C. K. Aldrich says "perhaps there will be more emphasis on professional complementarity than professional rivalry."[2] The reduction of rivalry will free the different persons in the mental health field to concentrate on treatment. The complementarity will reduce anxiety around status and allow for freer interaction between staff members and patients and staff.

It is the conclusion of these researchers that the multiple types of relationships in the milieu provides are the most meaningful aspect of the milieu to the patients. Where there is more cohesion and mutual respect among staff members, the patients experience less staff-doctor contradiction and more close relationships with the staff. When the competitive struggle is eased, more freedom and relaxed friendliness exists on the ward among staff and between staff and patients.

Another interesting finding in relation to the milieu was the emphasis on group activities. Across the board patients showed

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[1] Ibid., 53.

[2] C. K. Aldrich, "The New Approach: Intervention and Prevention: The Clinical Psychiatric Model", Social Service Review, XL (September, 1966), 269.

appreciation for occupational therapy, music therapy and recreational therapy. These therapies possess the advantages of providing the opportunity for "enhancement of self-esteem, a feeling of belonging and accomplishing" and for "nonverbal self-espression."[1] All three of these therapies provide both experiences in which the patient can work individually although there might be others around and group experiences in which the patients interact with one another. One difference between these group activities and patient meetings is that they have a purpose which is clear and participation can be expressed by doing something rather than necessitating verbal exchange around personal feelings. The patient may participate by playing on a team, singing with a group or helping to make something in a group project. Verbal exchange does occur, but for those who are uncomfortable in expressing themselves in this manner in a group there is another avenue of participation available.

Many patients, outside of Cottage II, expressed a dislike for patient meetings. One reason may be that this meeting requires verbal exchange around personal feelings about problems on the unit. Many patients are made uncomfortable by the expression of negative, angry or hostile feelings. They often fear these feelings in themselves. Another reason may be that the purpose of these meetings and the power of the patients is vague. There is a confusion about whether the expression of

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[1] Martin R. Towey, S. Wade Sears, John A. Williams, Nathan Kaufman and Murry K. Cunningham, "Group Activities With Psychiatric Inpatients," Social Work, XI (January, 1966), 53.

feelings is the main focus or whether the accomplishment of a resolution to the problem is the focus. Since the patients did not at the time of our study hold any power, the meetings often seemed like patients talking to parents. The patients would be asking the staff to do something and the staff members in return would throw the ball back to the patients saying let's deal with your feelings around it. There was confusion as to whether or not the problem itself held any validity within the context of patient meeting. This was never clear to us as observers and it did not seem clear to either the patients or the two staff members within the meetings observed on Unit A. This vagueness or lack of clear focus needs to be further investigated.

Psychodrama, which was held in Cottage I, received positive responses from patients regardless of sex, diagnosis and period of treatment. Like patient meetings this group functions on the level of dealing with personal feelings. Unlike patient meeting the focus is clear to all persons, patients and staff alike. The group has come together to act out situations which have presented problems to particular people in the group. The feelings are worked through and ventilated in the dramatic presentations. Persons within the group often have shared similar experiences or feelings and therefore can benefit from particular experiences portrayed in the dramatic sketches. Also the members of the group play the roles in the drama. Drama provides a medium for both expressing and working through problems and feelings. Drama allows the individual to be more objective in that his problem is presented "out there". It is laid out on the table and he

can speak of "it" instead of "me" which is not quite as threatening. Once he has been able to deal with the "problem" as an "it" he can slowly claim it as "my" problem and deal more directly with his particular feelings. The fact that all members of the group are struggling to express themselves offers support to each individual member. The presence of similar problems and feelings in other group members makes a patient feel less alone in his struggle. The appreciation of patients for psychodrama at Georgia Mental Health Institute was also expressed by a patient in another study, "I hope you never have to give up psychodrama. It is the only place we can really express ourselves."[1]

Thus the data of this study concerning psychodrama has shown that group activities centered around the expression of feelings can be appreciated and found very helpful by patients. This would tend to discredit any theory that patient meetings were not appreciated because they dealt with personal feelings which are threatening to patients. Patient meetings should be considered carefully in order to discern why they are not proving helpful to many patients.

It is the conclusion of these researchers that the specialized therapies of music therapy, recreational therapy and occupational therapy provide meaningful growth experiences for the patients. Also those group activities involving expression of personal feelings are found helpful when they are clearly focused and provide some medium

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[1] Rev. Philip Chase and Beverly Farnham, "Psychodrama in a Mental Hospital," Mental Hygiene, V (April, 1966), 265.

or some direction for ways to express one's self.

DISCUSSION OF FINDINGS REGARDING SOCIAL WORK SERVICE

Hospitalization of a family member whether a child, parent, spouse or other relative often engenders feelings of guilt, shame, hostility or fear on the part of the remaining family members. "Fear of exposure and guilt about their contribution to the pathology of the patient are common initial feelings experienced by many family members."[1]

The primary responsibility for the patient's family is that of the social worker who "brings to the professional relationship a keen interest in the individual, an ability to accept and respond with warmth to the personality structure and emotional needs of the individual and the ability to evaluate and understand personality without imposing moral judgment."[2]

As in any other problem situation, families of emotionally disturbed individuals need to feel that the social worker is genuinely concerned for them as individuals as well as members of a family group. They need to feel that the helping person understands the impact the patient's hospitalization has made on them.

In most instances, prior to hospitalization, the family has attempted to effect a change in the behavior of their emotionally

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1 Irving E. Alexander, "Family Therapy," Marriage and Family Living, XXV (May, 1963), 148.

2 Felix P. Biestek, "An Analysis of the Casework Relationship", Social Casework, XXXV (February, 1954), 60.

disturbed member either through their own efforts or through other community resources. The social worker's understanding and support of these efforts is an important aspect in relieving the frustrations felt by the family.

From the data collected in this study, in general the families receiving treatment at the Georgia Mental Health Institute emphasized their major concern in the personal quality of the relationship. This factor held true regardless of the variable studied. The answer "social worker's interest concern and availability" received the highest percentage of responses in regard to "what had been most helpful." This high percentage of responses indicates that families, like the individual patients, want the helping person to respond with warmth, and to be a person who shares their feelings.

The term mental illness has a frightening connotation for many individuals because of the lack of knowledge and the stigma which many families feel having a mentally ill member brings to them. The response given by families "better understanding of patient's problem and mental illness" is indicative of the responsibility the social worker has to educate the families regarding the nature and dynamics of mental illness.

Another concern expressed by families in this study was in the area of receiving "periodic progress reports regarding the hospitalized patient." This was expressed either in terms of "lack of information regarding's patient's progress" as not being helpful or in terms of "periodic progress report regarding patient" as being more helpful. The family of a hospitalized patient is usually quite concerned about the

progress or lack of progress the patient is experiencing and is appreciative of being allowed to share in this aspect of the patient's treatment. To exclude them may only serve to heighten their feelings of being a "bad family" and to increase their guilt feelings around their involvement in the patient's emotional problems. This engenders hostility which may become a barrier in helping the family to begin to resolve the internal conflicts within the family. This problem may possibly stem from lack of communication between the staff members who are responsible for the patient and the family.

If lasting benefits are to be derived from the therapeutic experience to which the patient has been exposed, modification of inimical family life patterns needs to be fostered. Usually the patient returns to the family after discharge from the hospital. Unless the conflicts within the family have been resolved or diminished, the probability of total recovery of the patient is decreased. Kenneth K. Berman in his study of the effects of multiple client family therapy in preventing readmission drew the fallowing conclusion:

> It is not enough to treat the patient who was hospitalized, but that the patient's family, his home milieu, had to be treated at the same time....reintegration and resocialization could be meaningfully attemped only when better insight, better judgment and better understanding could be brought to the entire family, at the same time and together.[1]

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[1] Kenneth K. Berman, "Multiple Family Therapy: Its Possibilities in Preventing Readmission," Mental Hygiene, L (July, 1966), 370.

SUGGESTIONS FOR FURTHER RESEARCH:

(1) One further area for research would be an attitudinal study comparing the attitudes of the adolescent patient, the patient's therapist and the social worker toward the parents of the adolescent .

(2) Another area of study might concern itself with the sociological implications of the changing role of women and the effect of this changing role on the way female patients are treated by mental health clinicians. It would be interesting to know if there is hidden staff disagreement in the way in which a female patient should be treated.

(3) Research might also be done in the area of how patients from different social classes respond to individual therapy, milieu therapy and social work service.

(4) Further research should be done studying the effect of sex, diagnosis and period of treatment on the patient's responses to treatment services. This study was limited in these areas because of the differences in sample sizes.

(5) The responses from this study could now be used to form a multiple choice questionnaire. The answers from such a questionnaire would lend themselves to more a statistical analysis than the present study, where an open-ended questionnaire was used.

(6) From this study, the implications are that the personal quality of the therapeutic relationship holds the greatest significance for patients and their families. This in itself could form an hypothesis for future study. One way a study of this nature might be approached

is to have patients and families to rate on a scale the personal quality of the therapeutic relationship, the supportive quality and the professional quality.

(7) Another area of interest might be a study concerning whether or not a periodic progress report from the patient's therapist would alleviate the family's feeling of being judged and therefore reduce the degree of defensiveness in the counseling relationship.

(8) Another area of study might be whether or not there is a relationship between the rapidity in which a patient is able to terminate as an inpatient and whether or not his family is being treated. A sub-hypothesis could be: of patients' whose families are being treated, does it make a difference if there have been joint sessions with the patient, patients' therapist, the family, and the social worker?

This study would have been enhanced if non-paremetric statistical techniques had been applied to the data in order to determine any statistical significance the variables, either singly or interrelatedly, may have had on the data. Such techniques should be mandatory in future studies in this area.

APPENDIX

QUESTIONNAIRE FOR PATIENTS

I. Regarding Your One-to-One Therapy:

A. What has been most helpful to you?

B. What one thing would be more helpful to you?

C. What one thing has not been helpful to you?

II. Outside of Your One-to-One Therapy:

A. What has been most helpful during your stay at the Institute?

B. What one thing would be more helpful?

C. What one thing has not been helpful?

LETTER TO THE FAMILIES

Georgia Mental Health Institute
1256 Briarcliff Road, N.E.
Atlanta, Georgia 30306

November 21, 1966

Dear

We are conducting a research study at the Georgia Mental Health Institue regarding the services offered to the inpatients and their families. We feel that you who are receiving our services can give us the most accurate evaluation of these services. For this reason, your opinions are of value to our study.

The inpatients will be completing a similar questionnaire concerning the services rendered directly to them. We are asking you to sign your name. Your responses will be held in the strictest confidence and will be seen only by the two of us.

For your convenience we are enclosing a stamped, self-addressed envelope in which to return your questionnaire. Will you please return the questionnaire no later than December 1, 1966?

Your answers will enable us to gain a clearer understanding of where our services are beneficial and where they need improvement. With your assistance, we will be able to be more helpful to future patients and their families.

Thank you for your cooperation.

Sincerely yours,

(Mrs.) Eleanor Bartlett

(Mrs.) Bobbie Ware
Social Workers
Unit A - GMHI

EB:BW/sc

enclosures

QUESTIONNAIRE FOR FAMILIES

In Your Relationship With Your Social Worker:

A. What has been most helpful to you?

B. What one thing would be more helpful to you?

C. What one thing has not been helpful to you?

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